DOCUMENT RESUME

ED 397 349 CG 027 153

AUTHOR Coates, Gail E.
TITLE The Development of Outcome Measures for a Family Preservation and Reunification Program.
PUB DATE 95
NOTE 120p.; Master's Practicum Report, Nova Southeastern University.
PUB TYPE Dissertations/Theses - Practicum Papers (043) -- Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC05 Plus Postage.
DESCRIPTORS At Risk Persons; Counseling Effectiveness; Counseling Services; *Family Programs; *Human Services; *Individualized Family Service Plans; Integrated Services; *Outcomes of Treatment; Postsecondary Education; Program Development; *Program Evaluation; Program Improvement
IDENTIFIERS *Family Reunification

ABSTRACT

In order to provide specialists and families with regular feedback on client change, to enhance the clinical decision-making skills of family specialists, and to provide target groups with information related to program effectiveness, a 12-week plan to improve outcome measures and evaluation protocol in a preservation and reunification program was proposed and executed. The plan included: (1) the selection of comprehensive, relevant instruments; (2) in-service staff training in the use of these instruments; (3) the revision of program documents; and (4) the development of a volunteer role to accommodate the proper collection and dissemination of outcome data. Based on analysis of data from a specialist questionnaire and client files, it was concluded that changes to program evaluation practices were small but promising. The findings suggest that family specialists are more familiar and satisfied with program instruments and the outcome data package. The consistent collection of clinical and research data continues to present a challenge, with competing work demands and the failure of staff to view evaluation as a priority undertaking as primary obstacles. Future evaluation endeavors must therefore include the reallocation of program resources, and program support for--and recognition of--the evaluator role. Ten appendices present instruments and documents used in the program. Contains 45 references. (TS)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

TM

ED 397 349

The Development of Outcome Measures for a Family Preservation and Reunification Program

by

Gail E. Coates

Cohort #8F

A Practicum Report Presented to the
Master's Program in Child Care, Youth Care, and Family Support
in Partial Fulfillment of the Requirements
for the Degree of Master of Science

NOVA SOUTHEASTERN UNIVERSITY

1995

BEST COPY AVAILABLE

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

G. COATES

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

CG027153

Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my own work, presented here, will earn similar respect.

Date _____ Signature of Student _____

Abstract

The development of outcome measures for a family preservation and reunification program. Coates, Gail E., 1995: Practicum Report, Nova Southeastern University, Master's Program for Child Care, Youth Care, and Family Support. Descriptors: Evaluation Evaluation/Problems Evaluation/Utilization Formative/Evaluation Summative/Evaluation Evaluative/Thinking Evaluation/Methods Critical/Thinking Family/Problems Family/Counselling Family/Programs Family/Support.

The problems associated with outcome evaluation practices in a preservation and reunification program are similar to those identified in the family support literature and by field practitioners. In part, the use of narrow or insensitive outcome measures, inadequate training in the use of instruments, and poor staff and consumer investment in the evaluation process have interfered with the consistent collection and holistic presentation of meaningful outcome data by family specialists alike.

In order to provide specialists and families with regular feedback on client change, to enhance the clinical decision-making skills of specialists, and to provide target groups with information related to program effectiveness, a 12-week plan to improve outcome measures and evaluation protocol in the program was proposed and executed. This included the selection of comprehensive, relevant instruments, in-service staff training in the use of the instruments, the revision of program documents, and the development of a volunteer role to accommodate the proper collection and dissemination of outcome data. These changes are represented in the appendices.

Overall, it was concluded that changes to program evaluation practices were small but promising. The findings suggest that specialists are more familiar and satisfied with program instruments and the outcome data package. A few reported using the data to enhance case planning and clinical decision-making. Further, management has adopted these practices as an integral part of program technology. Conversely, the consistent collection of clinical and research data, particularly at case follow-up, continues to present a challenge. Competing work demands and the failure of staff to view evaluation as a priority undertaking are primary obstacles. Future evaluation endeavors must therefore include the reallocation of program resources, and program support for and recognition of the evaluator role.

Table of Contents

Chapter		Page
I.	Introduction	6
II.	The Problem	12
	Problems associated with program evaluation practices	12
	Literature findings	14
	Information from practitioners	20
III.	Goals and objectives	26
IV.	Solutions	28
	Criteria for instrument selection	28
	Proposed Program Measures	32
	Considerations for the implementation of evaluation approaches	39
	Proposed solution strategy	41
V.	Results	46
	Implementation	46
	Findings	48
	Discussion	63
VI.	Conclusions	65
	Recommendations	66
	Final comments	71

References 73

Appendices 77

A Parent-Child Behavior Questionnaire and Child Behavior Checklist 77

B Specialist Questionnaire 83

C Family Assessment Device 90

D Personal Network Matrix 98

E Family Goal Recording, reproduced 102

F Specialist Questionnaire, post-test revisions 105

G Consent to Participate in Counselling form, revised 107

H Termination Format Letter, revised page 109

I Client Discharge Form, revised page 111

J Outcome Evaluation forms (Child Placement and Family Functioning) 113

CHAPTER 1
INTRODUCTION

This chapter provides an overview of the problem setting and my corresponding role.

The Setting

The practicum project focused on a family support program operating under the auspices of a local child and family service agency. The nonprofit private agency experienced its beginnings over 30 years ago as a residential treatment and education facility for children experiencing a variety of physical, behavioral, and emotional problems. Since then, it has spawned a host of programs, including treatment foster care, semi-independent living, and receiving and teaching homes, in response to the growing need for a continuum of community services. The most recent addition is a 7-year-old home-based family support program for high-risk children and families. Based on a philosophy that all families require support and that whenever possible family members belong together, their goal is to help preserve the family unit, to successfully reunite children and families; and as a last resort, to strengthen and maintain family relationships when out-of-home placement is necessary. Program statistics reveal that 85% of the referred children contacted at 1-year follow up are residing with immediate family, relatives, or friends. The support program offers a range of services to families in the rural and urban Calgary region, including a native program for North American Indians; a long-term program for families with chronic problems and complex needs; and a short-term program, which accommodates the largest staff and consumer group and serves families with a number of presenting problems. It is

this short term program that served as the clinical setting for the project.

The program is contracted by Alberta Family and Social Services to provide short term, intensive in-home support and 24-hour crisis support to a minimum of 650 children and their families who are referred annually by the Child Welfare Division. Each specialist carries a two-family caseload; and each family receives approximately 20 hours of weekly support in their home environment over a period of 8-12 weeks, with follow-up support available as needed. The referred children range in age from birth to 18 years.

Two of the agency's managing directors oversee the operation of the short term program, the native unit, and the long term program. These programs operate within a three-tiered organizational structure that consists of program directors responsible for administrative functions; coordinators who provide ongoing training, supervision, and consultation to front line staff; a volunteer coordinator in charge of recruiting and training program volunteers; family specialists, who provide direct support and treatment to children and families; program assistants, who aid specialists in carrying out treatment as required, and a full-time trainer-evaluator who was recently recruited to assess and revise program practices and procedures. Until 2 years ago, organizational structure, staffing patterns, and resources reflected contractors' beliefs that only extremely high-risk cases (the top 1% of "needy" families) warranted treatment. Since then, staff size has increased nearly threefold at the front-line level and proportionately at the management level; this is in response to an increase in funding dollars

BEST COPY AVAILABLE

for family support services and an awareness of the need to offer cost-effective, intensive, preventative services to families who might otherwise join the ranks of the higher-risk group. There are currently 11 family specialists serving the short term program.

An analysis of client profiles reveals that program families come from a range of socioeconomic, cultural, and educational backgrounds; present differently; and require support services that vary in degree and kind. In addition, they demonstrate various levels of engagement, cooperation, trust in professionals, and personal experience with formal systems. The heterogeneous nature of families necessitates a respect for family values and cultures, the active participation of families in their own treatment, and the individualization of services. Program emphasis is on creating and building on family members' strengths, and causal inferences and labeling are deliberately avoided.

The Family Specialist Role

Although specialists typically hold a bachelor's degree in the social sciences, each works as a member of a multi-disciplinary team that offers a range of educational, intra-agency, and field experience to the program. All specialists receive extensive pre-service training and ongoing training in the Teaching Family Model (TFM) of service delivery, acquire ongoing practical experience, receive regular consultation advice, and are encouraged by the agency to further develop professional competence through participation in program workshops, program development opportunities, continuing education courses, and inter- and intra-agency seminars.

The TFM, developed in 1967 and used widely by more than 30 Teaching Family Association agencies and programs and various non-members reflects a behavioral model of intervention, although a variety of cognitive and systems frameworks are incorporated into practice.

Regarding role expectations, trained specialists collaborate with families, assigned child welfare workers, community professionals, and program staff to maximize effective case management, alleviate child welfare concerns, and improve family functioning. The first 2 weeks of the intervention focus on relationship development, family assessment, and the formulation of a comprehensive family treatment plan that is used to guide the treatment process.

The primary role of the specialist involves skill teaching. Specifically, specialists work with participants on areas such as parenting, child behavior, rational decision-making, communication, and basic needs; and they facilitate the family's demonstration, maintenance and generalization of these skills. In addition, families learn new ways of viewing themselves and others, and of impacting their environment. This process is meant to empower, mobilize, and strengthen families to deal with ongoing anticipated and unanticipated life events that may otherwise prove stressful and detrimental. Other roles include activating temporary and long-term resources; serving as a case-level advocate; liasing with involved professionals and significant others; educating parents on child development and parental responsibilities; providing concrete assistance; and providing emotional support and counselling. An effective

specialist will create opportunities for learning and take advantage of existing situations, including crises to help the family acquire new skills. The specialist is available 24 hours daily to respond to crises, operates on a flexible work schedule, and offers follow-up support to former families as required.

In terms of administrative duties, documentation is considered an important specialist accountability and program measure. At case opening information on family history, demographic variables, and problematic behaviors are recorded on an intake form. In addition, program parents are required to sign consent forms to partake in counselling and for the release of family information, and are encouraged to consent to the transport of children, the possible use of physical restraints on children, and participation in family-based research. In order to participate in research, parents must complete Achenbach's Child Behavior Checklist and page 1 of the Parent-Child Behavior Questionnaire at intake, at case closure, and occasionally at 4-month follow-up intervals. This data is compiled by the program statistician and is used as program feedback.

In addition, daily contact notes and time sheets provide a record of treatment activities and treatment intensity. At case closure, a discharge form describing child placement and family "prognosis", and a termination letter documenting the progress toward goals are presented to child welfare. Over a 12-month follow-up period, families are contacted bimonthly and asked to provide child placement information. Occasionally, former participants are contacted by

available staff and asked to qualitatively describe which of the skills acquired during treatment are proving helpful, relevant, and replicable. Statistics on child placement at case closure and 1-year follow-up are shared with contract managers; the remaining data is compiled by the program statistician and used for practitioner and program feedback.

Due to developmental growth within the family support field and the short term program, the program is currently undergoing significant changes to its policies and procedures in areas such as formal staff training and evaluation, working conditions, and treatment documentation. By encouraging specialists' involvement in these processes, the program has recently witnessed improvements to staff practices, competence, feelings of empowerment, credibility, and morale. Having been certified according to Teaching Family Association (TFA) standards for my demonstration of competence in the area of family treatment, I am an active participant on the agency's Evaluation Review Committee, on the program's staff evaluation committee, and in the formal practitioner group meetings; and I serve as the Practitioner Representative for the home-based division of TFA, and as a representative on TFA's Board of Directors. Given the benefits of staff involvement, it is not surprising that the proposal to develop evaluative outcome measures in the short term program was widely approved following a discussion with upper-management bodies. Program staff were to be kept abreast of project developments.

CHAPTER 2
THE PROBLEM

This chapter describes the problems associated with outcome evaluation practices in the short term program, and discusses their relevance to other field practices. Information was obtained from literature sources and from practitioner colleagues and coworkers.

The Problems Associated With Program Evaluation Practices

Evaluation practices within the short term program were inadequate. Specifically, the outcome measures utilized by program staff were inappropriate, their application was inconsistent, and the outcome results were not properly utilized.

The program used page 1 of the Parent-Child Behavior Questionnaire (PCBQ) and Achenbach's Child Behavior Checklist (CBCL) (see Appendix A); open-ended parent questionnaires on family skills; and closed-ended questions on child placement, to assess child and family outcome variables. To some degree, each of these instruments played a role in the inadequate program evaluation practices described above: First, the inappropriateness of the instruments included the use of the CBCL. This measure, which is known for its ability to distinguish between clinical and nonclinical populations and among various types of clinical populations, does not effectively measure changes *within* clinical families like the high-risk families commonly enrolled in the short term program. Second, in reference to the inappropriate application of program instruments, there was an absence of consistent, timely, and regular interval testing involving all of the above measures: The PCBQ and CBCL were not issued to all

program families; further, specialists did not regularly implement the measures at case opening, case closure, and 4-month follow-up periods. In addition, family skill and child placement data were not consistently collected at regular intervals over 12 months of follow up with all program families. Finally, with respect to the inappropriate utilization of outcome data, the PCBQ and CBCL served a limited research function, so that none of the information was used as feedback for clinical decision-making by specialists; the data obtained from the open-ended questionnaires on skill demonstration were frequently not communicated to specialists; and global child placement data that did not include other relevant outcomes were used in the absence of other outcome data to justify program effectiveness to a variety of target groups, including specialists, professionals, and contract managers. It is important to note that while program staff collect specific data on child placement, the favorability of child placement was not ascertained. Of the three kinds of problems discussed here, the last two are the most significant, since the development of adequate instruments would have no positive affect on evaluation practices unless the problems associated with data collection and utilization were adequately dealt with.

The program needed to utilize evaluative outcome measures; the outcome measures needed to be used at regular intervals during case opening, closure, and follow-up with all program families; and the results needed to be shared collectively with target groups, and to contribute to research *and* serve as clinical feedback during treatment interventions.

BEST COPY AVAILABLE

Literature Findings

Evaluation constitutes a multi-disciplinary, diverse, complex, and controversial practice (Scriven, 1993) that has been described as "...a process of delineating, obtaining, and providing useful information for judging decision alternatives" (Dunst, 1991, p. 15). Several authors have attempted to bridge the gap between evaluation practices in order to emphasize their similarities and compatibility. For example, following an analysis of three heterogeneous studies, Yin (1994) concluded that effective evaluation studies represent a "singular craft" that is comprehensive and in-depth, successfully undermines the credibility of competing hypotheses, allows one to derive broad implications from evaluation results, and reflects a competent analysis of available data. Other authors (Powell, 1987; Reichardt & Rallis, 1994; and Royse, 1990) have argued that qualitative and quantitative study measures are complementary and contribute to the richness and accuracy (validity and reliability) of data collection and interpretation. Further, resistance and barriers to using rigorous experimental designs in natural settings (Powell, 1987) have lead to general consensus around the use of quasi-experimental designs to improve the reliability and validity of various methodologies and results, and to accommodate ethical considerations in research and program evaluation.

Despite these attempts, the social science field has been among the most criticized by traditionalists (Scriven, 1993) for its use of evaluation; critics claim that evaluation is marred by evaluator biases and political influences that can lead to subjectivity and inference. Scriven

(1993) contends that in reality, many social science studies are grounded in fact and logic, and that the inability of evaluators to adequately rationalize their conclusions is one problem all disciplines must confront. Nevertheless, this criticism is not lost on the field: To minimize the problem of evaluator and program bias, some programs (Jacobs, 1988) have engaged the services of outside evaluators to assess program effectiveness. Other individuals have attempted to minimize the problem of "scripted thinking" and worker bias: For example, in a study by Waxman, Rapagna, and Dumont (1991), the authors offer suggestions around educating counsellor-trainees to perform objective client assessments in ways that accurately depict the complexity of the human condition. The desirable evaluative attributes described earlier by Yin (1994) are consistent with these approaches.

The growing popularity of evaluation studies in the social science fields is evident from the numerous "program, product, personnel, policy, performance, and proposal" (Scriven, 1993, p. 310) evaluations being performed. For example, countless studies have been executed by education researchers to deal with matters such as bilingualism and the development of educational practices and theories (Fetterman, 1986). While program managers are obviously concerned with their own agenda, Scriven (1993) advocates that the needs of program participants be considered first and foremost. In this context, evaluation is an essential means of assessing the value or impact of a particular product or service on its recipients. This is especially relevant for the human service and helping professions.

Two kinds of evaluations are commonplace in family support programs and organizations: Respectively, formative and summative evaluations, which enhance program development and determine outcome effects on consumers and their larger systems (Littell, 1986) are compatible and have numerous advantages. Together, they support logical assumptions and generate factual information that can lead to quality assurance; increase program and staff accountability, credibility, and visibility; contribute to field practices and theories; enhance satisfaction and cooperation among funders and policy makers; facilitate program planning and replication; and most importantly, offer appropriate responses to consumer needs. Out of the growing need to secure and maintain funding, to provide effective services to a challenging and complex consumer group, and to take advantage of available information on family support and education programs, family support researchers and program staff are increasingly making use of these evaluation procedures. Many programs, such as the Child Survival/Fair Start for Children program for young mothers and pregnant teen-agers (Bond & Halpern, 1988) have conducted process evaluations to determine operational effectiveness; and others, such as the Advance Parent-Child Program (Rodriguez & Cortez, 1988) have implemented pre- and post-test measures to determine the impact of services such as parenting classes on disadvantaged families.

Ideally, effective outcome measures determine "...the extent to which exposure to a program changes the "targets" of the program in desired directions...significantly beyond ...those

directions that would occur in the absence of the program" (Rossi, 1992, p. 90). Functionally, these measures provide education and feedback to programs, workers, and participants during the assessment, intervention, and follow-up stages of treatment. In reality however, the problems associated with outcome evaluations in family preservation and reunification programs are well documented. For example, from his analysis of several family preservation programs, Rossi (1992) concluded that to date, programs have not been able to significantly or consistently demonstrate their impact on program participants. One major problem is that there is an over-reliance on narrow, single outcome measures, and these measures often reflect the particular "...political and social context of a program" (Powell, 1987, p. 321). Indeed, programs may succumb to social and beaurocratic pressures to alleviate vast social problems or serve as a cost-effective alternative to other social services. In addition, the complexity and diversity of the field's programs and families lead to difficulties in developing adequate instruments. This is evidenced by the popular use of child placement as a primary outcome measure. While keeping families together is a primary goal of preservation and reunification programs, the failure of a program to develop broader outcome measures and to appropriately justify their use can distort, limit, or mask the positive short term and long term effects of treatment. For example, Head Start (Zigler & Freedman, 1987), an early childhood intervention project initially relied on changes in child IQ as the primary outcome variable; however, when these temporary and unsubstantial effects diminished within a few years of school attendance, the programs were

widely criticized. Subsequent evaluation studies have revealed a number of positive outcomes for Head Start children, including enhanced social and emotional development. Service delivery and outcome measures have since expanded in order to create and capture more complex changes to children and families. Notwithstanding these improvements, the family support field has yet to develop a repertoire of reliable and valid outcome measures.

A second problem with outcome studies concerns the way these evaluations are performed and operationalized (Cole & Duva, 1990). The timing of outcome evaluations is paramount to success (Weiss & Jacobs, 1988); however, many programs conduct evaluations before their respective goals and procedures are firmly established. In addition, some programs do not conduct follow-up assessments with former clients, which can lead to the misinterpretation of outcome effects. One obstacle to follow-up is that families are mobile and difficult to track (Kinney, Haapala, & Booth, 1991). Even when assessments are conducted during and following an intervention, they are not always performed at regular or frequent intervals. The time and energy required by workers to perform unnecessary daily treatment documentation, and the level of participant cooperation may exacerbate genuine efforts. Further, the complexity of some instruments and their inability to capture subtle client changes (Wasik, Bryant, & Lyons, 1990) presents a challenge. This is in spite of competing rationales that regular interval testing can increase investment among workers and families, can be used to track gradual positive and negative changes in families, and can more accurately depict family outcomes (Wasik, Bryant, &

Lyons, 1990). Similarly, as with developing fields such as bilingual education, the absence of "...sound and practical guidelines and materials...." (Lam, 1992, p. 18) is a common problem in the family support field. While the field has begun to develop a handful of valid and reliable outcome measures, inconsistencies with respect to their use, coupled with disagreement on the targets of assessment (Powell, 1987) and over whether observational or self-report measures should be used can distort and limit outcome results. Further, every instrument has its advantages and disadvantages, which makes selection a double-edged sword. For example, depending on program needs, one may have to balance instrument reliability and sophistication with the degree to which it can be easily administered and scored.

Regarding operational inconsistencies, studies use different definitions of successful child placement (such as home versus out of home; with kin versus not with kin), organize their data differently (for example, according to number of families with children at home versus the number of children at home), and do not distinguish between higher and lower risk groups. In addition, the avoidance of out-of-home placement may be directly attributed to the program, even when it reflects the unwillingness of parents to place children, the inaccessibility of placement services, or the passing of family crises. Further, positive outcomes for family members can occur in spite of or because of child placement, and should therefore be considered. These methodological and conceptual problems (Cole & Duva, 1990) can lead to errors in the interpretation of outcome data.

Lastly, information gleaned from research studies of family preservation programs is not widely disseminated (Cole & Duva, 1990); and inconsistencies with and disagreement over the use of specific research designs make it difficult to cross-compare results or to select desirable evaluation approaches. In addition, the literature frequently reports narrow child placement data. As a result, many programs struggle in isolation and confusion to develop or reinvent adequate evaluation measures. Nevertheless, more sophisticated evaluation efforts are currently being conducted and documented. For example, the Family Connection Project family support program (McCroskey & Nelson, 1989) provides detailed information on their creation and pilot of the Family Assessment Form, and encourages other programs to analyze or utilize this instrument and provide them with feedback regarding its relevance and utility; and the Homebuilders program (Kinney, Haapala, & Booth, 1991) has published a book to provide others with information on the treatment and support of high-risk families. It offers a description of various program outcome studies, in addition to program outcome measures. Information on evaluation practices can be useful, as long as methodological approaches and concepts are carefully described and defined.

Information from Practitioners

To establish the relevance of the literature to the practicum problem and to obtain additional information on local family support evaluation practices, a Specialist Questionnaire (see Appendix B) was completed by 9 of 10 available specialists in the short term program, and

informal telephone interviews were conducted with family specialists from two local agencies. Due to the fact that no single Calgary service approximates the intensity of the short term program, I selected two medium-intensity programs that resemble the short term program along several dimensions (such as home visiting). Taken together, several themes emerged from the data.

One common theme involves the adequacy of program outcome measures. A worker from one local program stated that until recently, their primary outcome measure was a standardized social support measure that consists of the dimensions "function of support" and "aspect of support". She explained that the instrument is plagued by confusing terminology, making it difficult for families to comprehend and accurately respond to the questions, and difficult for staff to clarify the questions and interpret the results. Several workshops designed to train staff in the use of the instrument failed to alleviate the problems, which led them to conclude these measures were inappropriate for the program. As a result, staff were in the process of replacing the instrument with two standardized measures that are user-friendly and that depict several aspects of social support. The second worker explained that staff members actively participated in the creation of a multidimensional instrument that relies on specialist observations and includes a key for easy scoring and interpretation. Both workers felt that the usefulness of the instruments and staff participation in their development contributed to high levels of staff investment, despite the fact the instruments require considerable time to complete.

Similarly, information gathered from the Specialist Questionnaire revealed that most practitioners in the short term program did not find the PCBQ and the CBCL to be useful instruments because they fail to measure important family changes, and they do not provide staff with immediate feedback on family progress or on the effectiveness of specific intervention strategies. One inadequacy related to the restricted use of data for program development research. A second reason concerned the nature of the CBCL: While this child-focused measure of social competence and behavioral difficulties is considered comprehensive, valid, and reliable (McMahon, 1984), it does not address the impact of systems such as the family on child development (Mooney, 1984). Further, because the instrument is sensitive to differences among clinical populations, it is primarily used as a screening and outcome evaluation device, rather than as a treatment guide (McMahon,1984). Similar to the short term program, Homebuilders (Kinney, Haapala, & Booth, 1991) utilizes the CBCL as part of its evaluation package; however, the weaknesses of this measure are balanced by the use of clinical measures that can provide staff and families with regular, important feedback. While these measures are simple to administer, most of the specialists in the short term program reported that they are capable of performing clinical assessments but have not been adequately trained in the administration and scoring of these instruments; this can also contribute to staff perceptions that the measures are inadequate. With respect to child placement measures, specialists concurred that placement by itself is an insufficient outcome measure; and the majority of them felt pressured to ensure the

BEST COPY AVAILABLE

in-home placement of a child even if it was not in the family's best interest. Collectively, information provided in the literature and by family specialists indicated a need for the selection of appropriate outcome measures. For the short term program, clinically-relevant, practical, comprehensive outcome measures were required.

Another theme that emerged was the need for improved evaluation protocol, including the consistent and frequent use of instruments by family specialists. Regarding consistency, one worker reported that of three outcome measures utilized by program staff, no single measure or combination of measures was being consistently utilized by specialists; and decisions for their use were presumably being based on the specialist's judgment, rather than on specific program guidelines. Further, no follow-up data was being collected on families, because upper management believes that former-client contacts are intrusive reminders to families that problems once existed. The second worker reported that their multidimensional observational measure was being issued at case opening and closure; however, 4- and 6-month follow-up families were simply being asked to update specialists on their situation in narrative form, which affects the consistency of pre- and post-data collected. He also stated that case families are not aware that they are participating in observational assessments; while this can decrease family pressure to "rate" positively, it can restrict family investment in the treatment process, and it raises ethical concerns. Both workers rationalized that family mobility, worker time restraints, and limitations imposed by telephone contact interfere with the consistent, regular use of

outcome measures.

Specialists in the short term program also revealed inconsistencies with respect to the implementation of outcome measures: Some of the specialists reported their failure to request client participation in program research endeavors; and the majority of specialists admitted that they did not regularly implement research-based outcome measures with consenting families at case opening and case closure, and that they never did so at 4-month follow-up periods. Also, they and other program staff seldom collected child placement data during follow-up intervals. Staff indicated that it is difficult to implement the measures given their work demands, and that they do not feel the benefits of research are worthy of their efforts. Lack of knowledge regarding their use may also have been a contributing factor. Regardless of the number of individual-case families that agree to participate in research, most of the specialists attributed low levels of family investment to lack of understanding of the process, lack of trust, and the absence of direct benefits to their families. Given these criticisms, the consistent and frequent use of outcome measures was expected to improve as evaluation protocol and measures that provide practical feedback were introduced.

A related theme emerging from the specialist information was the appropriate organization and use of program outcome data. Programs prioritize and use outcome data in different ways. For example, in the medium intensity programs the primary outcome variable is the extent to which participants mobilize and utilize community supports. In the short term program the

primary goal is to preserve the family unit, which dictates the collection and dissemination of child placement data. Unfortunately, outside pressures such as limited funding can affect the way programs define success. Specialists in the short term program indicated that they have *never* included outcome data in their professional documents, shared outcome data with others during case conferences, or received child placement feedback from program staff. Most criticized the outcome data package (basic child placement data) for its inability to provide complete family information to target groups. Data needed to be clearly described and collectively presented, in order to improve evaluation protocol.

The descriptions of problems specific to this program were consistent with what was described in the literature and by local professionals. While the programs mentioned above had resolved some of the problems associated with evaluation practices, the short term program needed to address issues such as the usefulness of the evaluation package, staff training in the use of program outcome measures, guidelines for evaluation protocol, and the dissemination of relevant information to target groups Therefore, in Chapter 4, information gleaned from a literature review was used to guide the development of evaluative outcome measures and practices in the short term program, including solutions to evaluation problems, the selection of promising measures and approaches, and rationales for their implementation.

CHAPTER 3
GOALS AND OBJECTIVES

This chapter outlines the goals and objectives that served as the basis for this practicum project.

Practicum Goal

The aim was to develop and implement appropriate evaluative outcome measures for use in the short term program. The literature review and professional testimonies described in Chapter 2 provided valuable insight into the problems commonly associated with outcome measures used in family support programs. Of these difficulties, the use of measures that are too narrow in scope or that fail to depict important changes in program participants can significantly affect the adequacy of outcome measures. Program priorities, the complexity of family work, and the limited availability of evaluative instruments in part provide a context for the existence of these problems. Given the importance of meeting participant needs, there is little question that comprehensive evaluation measures are a necessary and desirable alternative.

The aforementioned information sources also revealed that the methodological problems commonly associated with program outcome evaluations in part stem from the complex nature of the programs, the families, and the field. These problems include the absence of standard guidelines and models, the inconsistent use of pre- and post-test measures, and the restricted use of outcome data. Limited staff and family investment in the evaluation process can exacerbate these problems. It was believed that the consistent implementation of outcome measures and the

appropriate use of outcome data would alleviate some of the methodological problems associated with evaluation practices.

Objectives

Based on the above goal, the objectives included the following:

(1) The program would select and/or develop outcome measures of greater clinical significance to practitioners and high-risk populations. These instruments would provide staff with adequate, relevant feedback on family changes and progress toward goals, as measured by the specialists' responses to a questionnaire I designed.

(2) Program specialists would become more familiar with how to implement program measures and how to interpret the outcome results, as evidenced by specialists' responses to the Specialist Questionnaire.

(3) The use of program measures by specialists during client intervention and follow-up phases would increase in the following ways:

(a) The percentage of specialists utilizing the measures would increase.

(b) Specialists would utilize the measures at more consistent intervals with case families.

(c) Specialists would utilize the measures at more frequent intervals with case families.

These objectives would be measured using data gathered from Specialist Questionnaire and client files.

CHAPTER 4
SOLUTIONS

This chapter focuses on solutions to the problem of inadequate evaluation practices in the short term program. Included is a review of professional sources that facilitated the identification of evaluative outcome measures and approaches. A proposed plan for their implementation is then described, and systematically presented in calendar form.

Criteria for Instrument Selection

Family assessment measures can be used to determine the severity of family difficulties, to provide workers with consistent information on family change and service needs, and to enhance workers' clinical decision-making (Gabor, Thomlison, & Hudson, 1993). In Chapter 2, the Child Behavior Checklist was criticized for its inability to capture important changes taking place within the program's high-risk families. In order to identify more appropriate clinical outcome measures for use in the short term program, it was helpful to consider some of the decisions faced by other evaluators and family support staff during the selection process.

First, Walker and Crocker (1988) organize family assessment measures into four categories: face-to-face interviews, projective techniques, observations, and self-report scales. Of these, self- report measures are among the most widely used. The reasons for their popularity exceed the relative ease and inexpense with which they are administered. Many investigators strongly believe that clients should be active participants in their own assessment and treatment. For example, Kinney, Haapala, and Booth explain that "the families have the best data about their

situation" (1991, p. 81); and Corcoran & Fischer (1987) refer to the client as a "very good observer" who can provide others with less available types of information . Also, Dunst, Trivette, and Deal's (1988) helping model of family assessment and intervention accommodates the use of self-report practices to facilitate "supportive encounters". They argue that outside evaluators who impose their own views on families run the risk of creating "oppositional encounters" that can impede family progress. Other authors (for example, Gabor, Thomlison, & Hudson, 1993) emphasize the importance of trusting worker-client relationships to facilitate honest disclosures from clients, and Rankin (1990) views deliberate and unintentional "client dissimulation" as an opportunity to promote client openness and change.

Other authors (for example, Weiss & Jacobs, 1988) hold that the use of observational techniques by trained outside evaluators is a more effective means of objectively measuring complex and subtle family interactions, despite the fact that these approaches are costly and occasionally spark opposition by program staff (Ellwood, 1988). They reason that self reports are susceptible to bias, and that evaluators disagree on whether reports should be aggregated or examined independently (Sawyer, Sarris, Baghurst, Cross, & Kalucy, 1988). Specifically, some authors believe that family members (Besharov & Baehler, 1992) and practitioners (Cole & Duva, 1990) are incapable of adequately assessing family difficulties, strengths, and needs, even though family members may alter their behavior during formal observations (Achenbach, 1985), and trained observers will classify or interpret behaviors in

different ways, which poses a similar threat to content validity (Weiss & Frohman, 1985).

To improve the accuracy of the information collected, Cole and Duva (1990) recommend that significant others, in addition to family members and workers conduct assessments of client needs and change. The selection of individuals for this comprehensive approach will depend on their capabilities (Corcoran & Fischer, 1987) and availability, as well as the availability of funding (Cole & Duva, 1990).

A second decision confronting evaluators involves the selection of existing instruments or the creation of new instruments. Corcoran and Fischer (1987) present their readers with criteria for instrument selection, and list numerous standardized child, adult, and family measures. The advantages to utilizing established measures include known reliability and validity, effective management of program resources (such as time and money), and the ability to conduct cross-program and participant studies. In cases where suitable standardized measures are not available, programs such as the Calgary Integrated Services and the Family Connection Project (McCroskey & Nelson,1989) have elected to develop their own measures. Powell (1987) recommends that new measures be piloted in conjunction with more established measures using small client samples. Staff may also elect to modify existing measures; however, this will alter their original reliability and validity values.

A third issue is the selection of practical instruments that match program resources. For example, because the majority of home-based family support practitioners hold a bachelor's

degree or less (Wasik, Bryant, & Lyons, 1990), it would be unrealistic to implement measures that require high levels of psychometric or statistical expertise. Similarly, many workers are operating under time and energy restraints. The ease with which rapid assessment instruments (RAI's) are administered and the level of comfort with which clients can express themselves make these measures popular; however, Corcoran and Fischer (1987) caution that the misuse of RAI's (or any other instrument) can affect validity and reliability; can result in an over reliance on the measures for decision making; and can create program resistance. Therefore, educating staff in the proper use of program measures is paramount.

Fourth, while the diversity of family needs and services make the selection of relevant, comprehensive measures difficult (Powell, 1987), program staff must select measures that reflect treatment objectives, and are of theoretical and clinical significance. Due to the nature of family preservation, the most common variables studied and measured are classified under family functioning, child risk and behavior, and social support (Cole & Duva, 1990). In addition, McFall (1986) points out that evaluators should use theoretical models to guide measurement selection, and that outdated or inappropriate instruments should be replaced with practice models that contribute to and accommodate new information. Another option presented by Corcoran and Fischer (1987) is the selection of measures that are not derived from any specific theoretical orientation. For example, Gabor, Thomlison, and Hudson's (1993) Family Assessment Screening Inventory measures the presence and severity of family difficulties

without providing reasons for their existence or means of alleviating them; users are therefore free to operate from within their own theoretical frameworks.

Finally, as evaluation practices become more complex evaluators increasingly rely on multidimensional or several single-dimensional instruments to adequately measure outcome variables. Cole and Duva (1990) rationalize that appropriate measures can then balance out less effective measures. Corcoran and Fischer (1987) recommend the use of measures where the target populations resemble program clients.

Having identified these qualities, it was possible to determine the needs of the short term program and to select adequate outcome measures based on these descriptions. Given the limited resources (time, money, and technical skill) of the program and specialists, the need for comprehensive clinical measures, and the time limit of the project, program staff needed to utilize one or more standardized self-report measures that are sensitive to changes within program families; are cheaply and easily administered, scored, and interpreted by program staff; and depict several relevant dimensions of family life. Several existing self-report measures met the above criteria and warrant analysis here.

Proposed Program Measures

In order to facilitate the selection of appropriate outcome measures for use in the short term program, numerous existing instruments that measure various aspects of family functioning, social support, and basic child and family skills were examined. Several promising measures are

included for discussion.

First, improving family functioning is an important goal of the short term program. Two suitable instruments, the Family Adaptability and Cohesion Evaluation Scales (FACES II and FACES III) and the McMaster Family Assessment Device (FAD), are described.

The Circumplex Model developed by Olson (Olson & Portner, 1983) is renowned for its widespread use in clinical and research circles. The adaptability and cohesion dimensions are represented in curvilinear form, with continuum extremes indicative of poor functioning. Communication is represented as a separate index that influences the direction of the two dimensions. The corresponding self-report measure FACES II is easy to use, and can be used by several family members and professionals to assess current and desired levels of family functioning. In addition, the measure can be used in various therapeutic settings, to enhance understanding of one's family of origin, and to assess functioning in the context of different developmental life stages (Olson & Portner, 1983). Showing fair to modest validity and reliability scores (Corcoran & Fischer, 1987), this measure has been criticized in part because of the use of small and non-representative samples during research undertakings. In one study involving 2,440 families, the authors (Green, Harris, Forte, & Robinson, 1991) found "lack of support" for the curvilinear relationship as measured by FACES III. These findings are supported by Perosa and Perosa (1990).

The McMaster Model is comprised of seven interdependent components of family

BEST COPY AVAILABLE

functioning that are measured separately using Epstein, Baldwin, and Bishop's (1983) Family Assessment Device (FAD) (see Appendix C). These dimensions include problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. One study (Miller, Bishop, Epstein, & Keitner, 1985) revealed that the measure is valid and reliable, relates well to social desirability, distinguishes clinical from nonclinical families, and adequately correlates with FACES II and the Family Unit Inventory. Other strengths include its ability to measure actual and desired family functioning levels, its utility as a clinical and research instrument, and its user-friendly qualities. Other authors also find the measure to be valid and sensitive to differences between clinical and nonclinical populations, in addition to response differences between parents and adolescents (Sawyer, Sarris, Baghurst, Cross, & Kalucy, 1988); and to be superior in sensitivity to FACES II (Fristad, 1989).

In light of the recent criticisms, research findings, and the content of these self-report measures, the FAD was deemed more appropriate for use in the short term program. It was hoped that the strong validity and reliability scores would strengthen the assessment package and balance any weak measures that were to become part of the evaluation package.

In addition to improving family functioning, short term program staff frequently help families mobilize community and professional resources that will adequately meet their needs; therefore, the selection of an appropriate social support measure was necessary. While studies show a positive correlation between social support and physical and mental health, child

development (Cleary, 1988), and parenting adjustment (Turner & Avison, 1985), the practical relevance of these findings is as limited as the availability of adequate social support measures. Cleary (1988) attributes poor theoretical-practical linkages to the failure of researchers to adequately define and measure support concepts and to understand how certain aspects of social support contribute to the achievement of treatment objectives. In his report on seven instruments, Tardy (1985) encourages his readers to adequately define various aspects of support. Both authors recommend that instrument questions be carefully examined and selected according to their program usefulness.

Several strong measures were disregarded during the student's search because of their poor fit with program objectives. For example, Procidano and Heller's (1983) Perceived Social Support Scale and Turner, Frankel, and Levin's (Corcoran & Fischer, 1987) Provision of Social Support Scale are valid and reliable measures of familial and peer support; however, they do not measure other kinds of support that program families might receive or find helpful. Other measures, such as Kaplan's vignettes (Turner & Avison, 1985) do not adequately distinguish among support aspects. Based on the program's need for an instrument that would succinctly measure the source, frequency, and adequacy of support received by families, Dunst, Trivette, and Deal's Personal Network Matrix (PNM) (1988) was selected. This instrument (see Appendix D) can be regularly used by practitioners to assess and record family needs, current and available supports, the frequency of contact with these sources, and how often these sources

can be depended upon for support. Blank spaces on one scale allow practitioners and families to list family needs and sources of support, while two self-report scales measure the frequency and dependability of familial, community, and formal supports. Designed as an assessment device, this instrument promotes an understanding of the complexity of social networks and allows clients and workers to examine means of activating supports. Unfortunately, the authors do not include validity and reliability values. Further, this type of assessment requires considerable time to complete. Notwithstanding these drawbacks, worker-client discussions on family needs and resources are an integral part of the assessment and treatment process in the short term program, so that the PNM could be smoothly incorporated into this process.

The third aim was to identify measures that could assist program specialists with treatment planning and implementation, and that fit the program's behavior-centered Teaching Family Model of service delivery. The Goal Attainment Scaling and Family Goal Recording instruments appeared to fit with program needs. First, the Goal Attainment Scaling was originally developed by Kiresuk and Sherman for use with mental health clients, and is widely used in a number of treatment settings, including the Homebuilder's project (Kinney, Haapala, & Booth, 1991). The measure is designed to provide feedback on client progress toward individualized goals. During the initial assessment phase, family members work with specialists to establish goals. For each goal area, families then describe current presenting behaviors and their rate of occurrence (in percentage form), followed by a list of 2-5 desirable and undesirable

outcomes and their rates of occurrence. Each set of projected outcomes corresponds to a 5-point scale ranging from "Best anticipated success" to "Most unfavorable outcome likely". The goal areas can be reviewed as often as needed to guide treatment and determine progress. This measure has several advantages: It is flexible, contextual, and focused; provides families with realistic expectations of their progress; and enables practitioners to track client change, remain accountable, and gather consistent, regular information. It is also important to note that the usefulness of this measure is largely determined by the way in which it is used. For example, the established goals may be unrealistic, there may be disagreement over which goals and problems are considered important, and the wording used may be subject to different interpretations. To minimize these problems, clear procedures and guidelines should be established prior to instrument use.

The second promising measure of family progress toward goals was the Family Goal Recording (FGR) (see Appendix E for reproduction) proposed by Fleuridas, Rosenthal, Leigh and Leigh (1990), which is a modification of the Goal Attainment Scaling. The most significant change is that each goal area is assigned a percentage value by family members to signify its level of importance. The original measure was revised to allow its users to make regular quantitative comparisons within subsystems and to accommodate a family systems approach. The authors found the new measure to be reliable and valid when used as part of an outcome evaluation package. The FGR can be used by practitioners to track clinical and outcome data,

and to determine the interplay of variables. While the validity and reliability of the instrument cannot be firmly established, it was felt that the education of staff in the use of the measure and the use of other standardized measures would balance any weaknesses. The use of this measure as part of the treatment planning and intervention process was intended to increase specialists' and families' investment in the evaluation process and increase treatment effectiveness.

Each of these outcome evaluation measures and their corresponding focus area and implementation schedule is summarized in table form below.

Table 1

Description of Program Outcome Measures

Instrument	Focus	Schedule
1. McMaster Family Assessment Device (FAD)	Family functioning	Case opening/closure 4-month follow up
2. Personal Network Matrix (PNM)	Social support	Case opening/closure/ as needed/4-month follow up (2 scales)
3. Family Goal Recording (FGR)	Goal attainment	Case opening/closure/ biweekly/as needed

Considerations for the Implementation of Evaluation Approaches

Having identified the evaluation package, it was important to examine appropriate ways to employ these instruments so they would prove useful. Several methodological issues are discussed here.

First, program staff must be adequately trained in the use of outcome measures (Corcoran & Fischer, 1987). Specifically, practitioners need to be knowledgeable in the way instruments are presented, administered, scored, and interpreted. This includes an understanding of the rationales that can increase staff and family investment, such as enhanced clinical decision-making, quality assurance, staff accountability, and ethical conduct.

Second, it is important to determine who will collect the data (Corcoran & Fischer, 1987). Self-report measures can be completed by program staff, family members, or significant others. Some authors (Wasik, Bryant, & Lyons, 1990) even suggest that data gatherers and respondents share the same culture and racial backgrounds. In the short term program, it was important that specialists record the information, since families vary in their ability to understand written material without assistance and to follow through with responsibilities; they may respond differently to less familiar people; and specialists would want to work collaboratively with families and significant others to establish goals or modify family information to accommodate professional opinions and concerns.

The third issue concerns the frequency and consistency with which the measures are

administered. Authors concur that regular assessments enable one to plan intervention strategies, focus on different family members, engage families in the treatment process, track client change, and determine the effectiveness of intervention techniques (Wasik, Bryant, & Lyons, 1990). Specifically, Corcoran & Fischer (1987) recommend that measures be issued no more than twice weekly to avoid client burnout or over reliance on instruments, and that Rapid Assessment Instruments be issued on a weekly basis. In the short term program, specialists were to adhere to the following schedule (see Table 1): To gather necessary pre- and post- outcome data on client progress in the short term program, the FAD and PNM would be issued at case opening and closing; to provide specialists and families with clinical information during the intervention, the PNM will be issued as needed; to provide information on long-term outcomes and to do so in a way that will maintain staff and client investment and cooperation, the easily and quickly-administered FAD and 2 of the 3 PNM scales would be issued at 4-month follow up; the FGR could provide specialists and families with regular feedback to assist them with meeting treatment goals, and would therefore be used at case opening, closing, and biweekly or as needed during each client intervention; and to provide target groups with a comprehensive picture of family outcomes in this family preservation program, staff would continue to collect child placement data at bimonthly intervals over a 1-year follow-up period.

Fourth, the setting has been identified as an important consideration (Corcoran & Fischer, 1987). Problems that are setting-specific should be assessed in the corresponding environment,

while more general problems can be measured where convenient, providing the locale remains consistent. For home-based specialists and families, the home environment may be well suited because it is a convenient and frequented location, important family transactions and problems are likely to occur in this context, family members generally feel at ease on their own "turf", and sensitive issues can be openly discussed and without the risk of being observed or overheard by outsiders.

Finally, different outcome measures should be combined to maximize effective decision-making. Corcoran and Fischer (1987) recommend the combined use of self reports, observations of client behaviors, and client-kept records to provide workers with different perspectives and increase the accuracy of data collection and interpretation. In the short term program, current measures include self reports, informal observations by program staff and other professionals, and specialist contact notes. It was anticipated that the consistent, regular use of the new outcome measures would strengthen existing practices.

Proposed Solution Strategy

It was decided that the above three measures (the FAD, PNM, and FGR) would be introduced for use in the short term program, based on the aforementioned program needs. Several specialists were approached, and stated their preference for the new measures over the current ones. To ensure the appropriate utilization of these measures, training was to be provided to staff in the administration and scoring of the instruments, in their significance to practitioners

and families, and in the importance of their regular, consistent use across program families. Policies, client consent forms, and termination format letters would be modified to accommodate the use of these measures and the documentation of results, and I would collaborate with senior management staff to devise a means for recording and disseminating outcome data to program staff and other target groups. In order to measure changes to staff evaluation practices, information would be collected from client files and the program's statistical records at the beginning and end of the implementation period, and specialists would be asked to complete the Specialist Questionnaire at the end of the implementation period.

It was predicted that client sample sizes and the number of pre- and post- client assessments performed would be significantly restricted by the timelines of the practicum project. To compensate for this, the specialists would be instructed to conduct assessments appropriate to their stage of involvement with clients. For example, specialists who were midway through treatment or were closing with families would be required to issue these measures. It was felt that these measures would provide valuable information at any stage of the intervention. Finally, specialists would still be required to request consent from families to participate in research and complete the Parent Child Behavior Questionnaire currently in place. When specialists and families began to feel more invested in the evaluation process, they would likely be more willing to contribute to the program's development.

Ten Week Plan

The proposed 10-week plan was as follows:

Weeks 1 and 2: First, a clause is added to the "Consent to Participate in Counselling" form to allow staff to collect family information using the new outcome measures; and termination format letters are modified so specialists can include statistical and clinical outcome data in their Child Welfare reports. Next, the new measures are copied, packaged, and stored in the program forms file for easy access. Finally, the staff group receives training in the use of the new measures, including their implementation, scoring, and interpretation. Time permitting, the trained specialists begin to implement the new outcome measures.

Week 3: Consultation with the program statistician takes place to determine the importance of program research endeavors. This information is shared with the specialists, who are then encouraged to issue "Consent to Participate in Research" forms to case families at case opening, and to issue the PCBQ to consenting families at case opening and closure. Specialists continue to implement the new measures.

Week 4: In order to establish a baseline for evaluation practices, family files and program records are examined to obtain information on the number of families that have agreed to participate in program research, the number of specialists who have utilized the CBCL and PCBQ, and the frequency and consistency of data collection by specialists, over the last 6 months. Specialists continue to implement the new measures.

Week 5: In order to establish a baseline, records of staff contacts with follow-up families are examined to determine the consistency with which child placement data has been collected over the past 6 months, in addition to the content of the data collected. Specialists continue to implement the new measures.

Week 6: A meeting with senior staff takes place to discuss improvements to data collection procedures involving follow-up child placement data. Also, the development of an evaluation report book that collectively presents the data compiled on child placement, family functioning, social support, and family skills is proposed, and the important targets of dissemination are ascertained. Specialists continue to implement the new measures.

Week 7: Efforts focus on the development and refinement of an evaluation report book, and the expansion of program assistant roles to include the regular collection of child placement data at follow up. Specialists continue to implement the new measures.

Week 8: Early data obtained from the Specialist Questionnaire and program files are organized into table form. The compilation of information related to the use of the three new outcome measures begins. Specialists continue to implement the new measures.

Week 9: The Specialist Questionnaire is issued to specialists on Monday, and the completed forms are collected on Friday. Specialists continue to implement the new measures.

Week 10: Pre and Post results taken from the Specialist Questionnaire, program records, and client files are compiled, contrasted, and presented in table form; and statistics on the past

and current implementation of the research-based PCBQ are compared. The results are shared with the staff group.

It was anticipated that several factors could interfere with the above activities. First, staff might have decided to book holiday time, which would limit the number of staff available for scheduled meetings and the number of specialists present to regularly implement outcome measures and complete the Specialist Questionnaire. To compensate for this, 2 weeks would be reserved in addition to the 10 weeks allotted for the implementation phase. Also, specialists covering for absent case specialists would be required to perform family assessments using the new measures, so that these results could be shared with each case specialist and included on the Specialist Questionnaire. If one Program Director was unavailable for staff meetings, the second Program Director or another authorized person had agreed to be present in his place. Finally, vacation schedules would be consulted and the Specialist Questionnaire issued to on-leave specialists at an earlier date, should their absence coincide with the pre-scheduled administration of the questionnaire.

The activities were to be tracked using a weekly record sheet with corresponding check boxes and spaces in which to comment on the process.

CHAPTER 5
RESULTS

The aim of this practicum was to develop and implement appropriate evaluative outcome measures in the short term program. The literature findings and practitioner information presented earlier substantiate the need for practical, comprehensive measures; the consistent, timely administration of these measures by trained staff; and an outcome data package that provides useful information on client change to a wide range of staff and consumer groups. To attain the project goal, this information was used to formulate objectives and guide the implementation of specific solution strategies over a 12-week period. This chapter includes a summary of variations to the proposed strategies, a presentation of project results and explanations for their presence, and a discussion of key problems as they relate to the present and future attainment of project objectives.

Implementation

While the implementation plan outlined in Chapter 4 was essentially followed, several anticipated and unanticipated variations in the timing and outcome of the proposed strategies transpired. First, four absent specialists received training subsequent to the staff evaluation workshop, several specialist and management meetings were rescheduled when unanticipated work obligations took precedence, and three specialists who had scheduled work leaves and vacation time completed the post questionnaire 1 month prematurely. To offset the potential consequences of these changes, the 10-week implementation period was extended to 12 weeks to

provide specialists with every opportunity to utilize the program measures and receive feedback prior to the collection of post-test data in Week 12. Second, substantial program funding cuts by Social Services forced the elimination of the Program Assistant role, which meant that the assistants would not be accountable for the collection of child placement data, as was originally proposed. To compensate for this, specialists were deemed responsible for collecting this data from their former clients, which I volunteered to collate and disseminate every 3 months along with 3-month follow-up data on family functioning. While budget cuts served to highlight the need for improved evaluation practices, the loss of program staff (Program Assistants, the Trainer/Evaluator, clerical staff, and the statistician), an upcoming increase in specialist caseloads, and an increase in specialist evaluation responsibilities has placed added demands on staff resources. Third, to increase the sample size, it was decided that the Native Program (consisting of two staff members) would also participate in the project, and that the data would be included in pre- and post-test results. Finally, meetings with the program statistician, agency staff, and outside professionals failed to yield any strong rationales for the continued use of the Child Behavior Checklist (CBCL) and the Parent Child Behavior Questionnaire (PCBQ). Nevertheless, staff were encouraged to collect PCBQ data, so it could be used together with program data to identify family functioning patterns.

In terms of the post-test results, these factors could have had an impact on staff investment and follow through. Other possible explanations are presented in conjunction with project

results.

Findings

The first practicum objective was to select outcome measures that would provide specialists with clinical feedback on family changes and progress toward treatment goals. During the evaluation training workshop, criteria and rationales for the selection the Family Assessment Device (FAD), Personal Network Matrix (PNM), and Family Goal Recording (FGR) as replacement measures were provided to staff, who were then directed to implement the measures with case families. The Specialist Questionnaire (see Appendices B and F) was used as a pre- and post measure of the appropriateness of program instruments.

The results revealed that the new program instruments are of greater clinical value than the former instruments. Specifically, during the pretest phase 22% of the practitioners reported that program instruments were useful for measuring changes that take place within program families, while post-test results revealed that 44% found the newly-implemented measures to be sensitive. Further, during the pretest phase 33% of staff reported that the outcome data were consistent with their own observations regarding family situations and progress, compared to 67% at post-test. These data are highlighted in Table 1, along with percentages constituting unfavorable staff responses and the absence of responses (symbolized by "NA"). (Note: Table categories were created by collapsing data that did or did not appear in the first and second, or third and fourth questionnaire response sets.)

Table 1

Practitioner Responses to a Pre- and Post Questionnaire

Items	*n*	% Responses		
		Favorable	Unfavorable	NA
		Appropriateness of Measures		
1. Sensitivity of instrument				
Pre	9	**22**	67	11
Post	9	**44**	--	56
2. Data consistent with workers' observations				
Pre	9	**33**	22	44
Post	9	**67**	--	33
		Adequacy of Staff Skills and Training		
10. Statistical analysis of data				
Pre	9	**33**	67	--
Post	9	**78**	22	--
11. Clinical analysis of data				
Pre	9	**56**	44	--
Post	9	**78**	11	11
12. Adequacy of training				
Pre	9	**11**	89	--
Post	9	**78**	11	11

At post-test, several of the specialists who answered NA commented that they have not had or taken advantage of opportunities to use the measures with case families. In part, this could be due to the fact that actual case openings outnumbered the closings and follow ups, which restricted the pre and post use of the measures. Also, the benefits of data collection were limited in cases where specialists were late into their interventions. In these instances, the majority of clinical decisions had already been made, so that additional information provided by the measures would not have been useful. Of the specialists who did use the measures, the FAD and PNM were cited as those used most frequently (only one formally reported using the FGR). This is probably because of the ease with which the scales are administered and interpreted. The time-consuming nature and complex presentation of the FGR (see Appendix) could in part account for its limited use. Had the FGR been used by more specialists, they would have been able to track client progress more frequently during the implementation phase. Indeed, one specialist informally commented that the FGR was a valuable and sensitive measure that facilitated progress in a "difficult" family. Notwithstanding this feedback, the staff polled at post-test either felt positive or uncertain about the new measures, while pretest results revealed a predominantly negative view of program measures.

In summary, although the results are less significant than was anticipated, one can conclude that the first objective has been partially met.

The second objective was to have the practitioners become more familiar with and skilled in

the implementation of outcome measures and the interpretation of outcome data. This entailed training staff in administration and scoring procedures, and initiating contact with staff to answer questions or update them on recent modifications to program evaluation practices. Again, the Specialist Questionnaire was used as a pre- and post measure of improvements to staff familiarity and competence (see Table 1). The data revealed an increase in specialists' familiarity with the use of evaluation measures. Respectively, 33% and 56% of specialists initially reported an ability to statistically and clinically interpret test data, compared to 78% during the post-test period. Further, evaluation training was deemed adequate by 11% of pretest staff, compared to 78% at Week 12.

Staff commented that while training was instrumental in developing competence, the practical application of the measures constituted a significant part of the learning process. This would explain why most of the specialists who rated their skills and training positively had utilized program measures at some point during the implementation period. The fact that specialists had no previous experience in the statistical and clinical interpretation of program outcome data would also explain why training by itself has failed to significantly increase the reported skill level of some specialists. Of those who rated their skills and training unfavorably, most commented that they felt confident their skill level would increase with instrument use. Again, of the three current measures, the FGR was the least familiar to staff, even though it requires the evaluator to perform simple calculations and design goals using basic interview

skills. It is possible that since all practitioners are required to formulate comprehensive treatment plans with their clients, the FGR was viewed as a redundant exercise. Further, one specialist attempted to use the measure commented that it did not "fit" well for a particular family. Again, poor investment in the use of the FGR could account for its limited use, which in turn could affect specialists' perceived level of competence and degree of familiarity.

Taken together, these outcomes reveal that the second objective has been partially met. The data on the adequacy of training are particularly significant and promising.

The final objective was to increase specialists' use of program measures. This translates to an increase in the *number of specialists* using the measures, an increase in the *consistency* with which interval testing is conducted with case families, and an increase in the *frequency* of testing. Progress toward this three-part objective was measured using the Specialist Questionnaire and client file data. (Note that only cases that had opened, closed, or been closed for 3 months during the implementation period were included as client file data.) As part of the solution strategy, in-service training was offered to supervisors and front-line workers in order to maximize staff accountability and participation at all levels. These participants received verbal instruction, written information, examples of instrument use and scoring, and timetables depicting schedules for the use of program measures. Written and verbal reminders regarding instrument use were also issued to front-line staff, and supervisors were asked to ensure practitioner follow-through during their supervision consultations. To facilitate data collection

by staff and to enhance the acquisition of client file data for this project, each practitioner was provided with a booklet in which to record and store outcome data and program documents. In addition, a clause was added to the "Consent to Participate in Counselling" form (see Appendix G) to allow all practitioners to collect outcome data as part of the treatment process. Staff were also encouraged to obtain client consent to participate in research.

In response to the first part of this objective, client record data revealed that 82% of specialists sampled had obtained at least *one* written client consent during the 6-month pretest period to use outcome data in program research. Seventy-one percent of this group took advantage of the opportunity to implement program instruments. This constituted 59% (n=17) of the entire specialist group. Conversely, by the end of the 12-week project, the new counselling consent forms were obtained by only 46% of all specialists; 54% (n=13) of the entire group had used one or more of the new measures on at least one occasion; and signed research forms were obtained by 77% of specialists. This would suggest that the number of specialists using program instruments has neither increased or decreased, that the number who obtained authorized counselling forms was insignificant, and that the number who received authorized research forms has not significantly changed.

There are several possible reasons for this. First, one specialist reported that she carried no case families during the study period, while others explained that they were midway through client interventions, and therefore did not feel these measures would benefit treatment. Since

these measures were promoted primarily as clinical instruments and secondly as research instruments, it is likely that the costs to specialists (for example, the poor timing of the clinical instruments and the effort and time commitment involved in their use) outweighed the perceived (research) benefits. The brief duration of the implementation phase would further support this type of reasoning. Another explanation is the absence of consistent follow-through at the supervisory level. One supervisor and one specialist commented that the majority of program coordinators (with the exception of my supervisor) did not strongly encourage or monitor the use of the measures among their supervisees. Finally, some copies of the outdated consent forms remained in circulation, and were being used in place of the revised ones. The fact that specialists collected outcome data without securing the proper consent, and that others received client consents but did not implement the new measures with these families indicates that the use of counselling consent forms neither created or detracted from specialists' opportunities to conduct client evaluations. Taken together, the results do not imply that staff lack good intentions or insight into the importance of program evaluation. On the contrary, several workers commented that they planned to use the measures once they have opened with new families, and 67% of specialists acknowledged that the new measures were beneficial to the program, compared to 11% at pretest.

In summary, the number of specialists using program measures has failed to increase. Therefore, this portion of the objective has not been satisfactorily met.

Regarding an increase in the consistency and frequency of outcome testing, staff adherence to the evaluation schedule is presented in Table 2, in the form of staff responses to the Specialist Questionnaire, and the actual number of consent forms and instruments completed by practitioners with case families. To reiterate, counselling forms were modified to facilitate the clinical use of measures *and* increase the likelihood that program participants would agree to participate in program research endeavors if direct treatment benefits were available. In addition, staff were told that the PCBQ might provide useful information when used in conjunction with the FAD, even if professionals could not justify its use. Finally, the follow-up interval was shortened from 4 months to 3 months to coincide with the collection of child placement data, and to increase the likelihood that former clients could and would be contacted.

Table 2

Specialists' Actual and Reported Adherence to Evaluation Pre and Post Schedules

Items	% Adherence			
	Reported	*n*	Actual	*n*
3. Request written consent				
Pre	**75**	9	**64**	61
Post	**72**	9	**22**	32
4. Issue measures at case opening				
Pre	**33**	9	**20**	61
Post	**56**	9	**25**	28
Issue measures at case closure				
Pre	**11**	9	**1**	36
Post	**22**	9	**21**	19
6. Issue measures at follow up				
Pre	**0**	9	**0**	14
Post	**0**	9	**0**	7

The consistency of measurement use is addressed on two levels: The *overall* consistency of measurement use (reported and actual) among specialists within each test interval , and the consistency of measurement use *within* family interventions. Pretest data depict a lack of consistency regarding overall staff adherence to evaluation schedules (see Table 2). Specifically, staff obtained written research consent from 64% of their clients, and the measures were implemented only 20% of the time at case opening, 1% at closure, and 0% at follow up. Although the figures are modest, the post-test staff group was generally more consistent in their follow through. Specifically, 22% of client counselling authorizations were obtained, and program measures were issued 25% of the time at case opening and 21% at closure. As with the pretest group, the specialists collected no follow-up data during this period. Note also that the PCBQ was utilized by only one specialist from the post-test group. While specialists rated their follow-through much higher at pre and post than was actually the case, they were aware that their adherence to the evaluation schedule tapered off from case opening to case follow-up, which was the actual trend described above. This discrepancy between self reports and client file data appears greatest in the first half of the schedule.

In terms of specialist consistency within client cases, specialists issued at least one of the measures according to the schedule 9% of the time at pretest, compared to 28% at post-test. The FAD and PNM were used as required by most of these post-test workers. The measures were most commonly used at case opening and closing, less commonly used midway through

BEST COPY AVAILABLE

interventions (this is tabled under case opening), and not at all at case follow-up.

Several explanations for these trends are possible. First, many staff explained that they received verbal consent from clients to use the new measures, which could account for the discrepancy between the number of reported requests for consent and the actual number of consents obtained. Also, the specialists who did not complete and return the Specialist Questionnaire might have been among those who did not use program measures. Had their responses been included, it is possible the reports would more closely match the actual results. Second, perhaps staff based their self-reports on the number of perceived opportunities versus actual opportunities to use the measures (recall the cost benefits described earlier). For example, if it was felt that the measures would not benefit the treatment of a particular family, this may not be viewed by specialists as an opportunity.

Third, the lack of consistency within case families at post-test could stem from the fact that specialist were nearing the end of an intervention, and decided against testing until case closure. These late interventions were classed as opportunities (*n*) under the case opening results, which may have had a negative effect on the project results. Fourth, while staff were provided with rationales for the consistent use of the measures, they expressed their reluctance to contact former families. Their lack of motivation and not the decline of families could therefore account for the continued absence of data collection at follow up. Indeed, 56% and 44% fewer staff attributed families' reluctance to participate in research to uncertainty around their commitment

and the absence of treatment benefits, although program confidentiality and ethical assurances remained unchanged at 56%. Fifth, given the absence of rationales for and lack of training provided in the use of the PCBQ, and the priority given to the piloting of new measures, it is not surprising that only one specialist completed the PCBQ.

In summation, there was a small yet promising increase in the consistency of measurement use, especially within case interventions. Therefore, the second part of the objective has not been adequately met.

These same results look different when the frequency of instrument use among specialists is examined (see Table 2). It has already been surmised that requests for written client consent and family cooperation are not strongly related to the consistency and frequency of instrument use by specialists. Notwithstanding the decrease in requests for consent during the post-test phase, there was no substantial change in the frequency of testing at case opening (20% versus 25%), closure (1% versus 21%), and follow up (0%) during the implementation phase. (Note that prior to calculating percentages, the completion of a single pretest instrument per child and a post-test instrument per family was valued at 0.5, and the completion of two or more measures was valued at 1.0.) The most impressive increase occurred at post-test, when instruments were administered to 20% more families at case closure than during the pretest interval. Again, together staff rated the frequency of instrument use higher than was actually the case. Not surprisingly, the majority of staff (78% at pretest and 67% at post-test) identified work demands

as the primary obstacle to instrument use. This is in spite of the fact they feel the new instruments contribute valuable information to the program and to program research. Again, it would appear that the perceived costs (time, energy, and the timing of the interventions) outweigh the benefits (enhanced clinical decision making and program development) of frequent instrument use by specialists.

The results show no significant increase in the frequency of instrument use, meaning that this portion of the objective has not been attained. This in conjunction with the aforementioned results suggest that although increased measurement use by specialists was anticipated, it did not occur.

Finally, although it was not formally included as a project objective, attempts were made to improve the use of outcome data by program staff. It was felt that this would contribute to staff satisfaction with evaluation changes. First, staff were encouraged to share outcome data with other case professionals. In addition, a final sentence was added to the Termination Format Letter (see Appendix H), prompting staff to use statistical and clinical data to substantiate the assessments, treatment approaches, and recommendations described in their reports to Child Welfare.

According to data gathered from the Specialist Questionnaire, there was a small increase in specialists' use of program outcome data. Specifically, at pretest 0% of workers stated that they used the data to enhance their clinical decision-making, compared to 22% at post-test. Further,

0% indicated that they share the data with other professionals, while 33% did so at post-test. Of those who did not make use of the data or who have not yet collected data, most explained that they intend to do so in future. Only one worker reported that the FAD (alone) produced insufficient data. Again, it is likely that specialists will develop confidence in using and sharing data once their familiarity with the measures increases. Earlier findings suggest that specialists have not yet reached this level of confidence.

Next, the development of a comprehensive data package including child placement and family functioning data was introduced for discussion at management meetings and was later shared with the staff group. Because the collection of child placement data was inconsistently collected (it was more than 6 months behind), it was suggested that Program Assistants permanently assume this responsibility. The Program director instead elected specialists responsible for collecting this tri-monthly information from their former case families. (It was later discovered that the Program Assistant positions were being eliminated.) To address the problem of narrow child placement data, Client Discharge forms were modified (see Appendix I) to include information on the projected future placement of children living in restrictive settings, and to help professionals ascertain the favorability of out-of-home placement. Next, two forms (see Appendix J) were created so that child placement and family functioning data could be presented collectively to program staff, contract managers, and other professionals on a regular (tri-monthly) basis. The first sheet includes child placement, reporting period, sample size, and

long-range planning information, while the latter sheet displays the reporting period, sample size, and client pre- and post-test FAD scores related to seven aspects of functioning.

Lastly, specialists were asked to gather 12 months of child placement data, and I compiled and displayed 3 months of recent data on the new form for staff to view. Due to the lag in data collection, this sample size was limited to 66 of 143 possible cases, with 6 of them incomplete. It is hoped that prompting specialist at more regular intervals will increase future sample sizes. Family functioning data will be made available to staff during the next reporting period. It is likely this will also increase staff satisfaction with the outcome evaluation package and the consistency of feedback.

As a result of these recent changes, the number of positive staff ratings regarding the consistency and frequency of data collection increased from 11% to 56%; the appropriateness of child placement data and the outcome data package increased from 22% and 0% to 44% and 67%; and staff ratings of their participation in data collection was 11% higher. Further, staff reported feeling slightly less pressured to ensure in-home child placement. Together, these results suggest that staff feel more positive about the collection and use of child placement data.

It is important to note that while the size of the pretest respondent group was modest, the post-test group matched it in size and included many of the original specialists (even though fewer specialists returned the questionnaire at post-test). It is hoped that this will increase the validity of project results. In addition, a total of three client files (two at pretest and one at

post-test) were missing from the program storage units, and were therefore not included in the results. The large client data sample would likely compensate for these omissions. Finally, pretest client file data was gathered over a 6-month period, while the implementation phase covered only 3 months. Had the implementation period been 6 months in duration, it is felt that staff ratings and client file data would reveal an increase in measurement use.

Discussion

Despite a modest increase in specialists' familiarity and satisfaction with program measures, the overall results of this study, particularly as they relate to instrument use, were unimpressive. While explanations for the negative and positive results have been offered in the context of project objectives, this discussion will focus on those having the greatest impact on evaluation practices in the short term program.

First, it is believed that the limited duration of the implementation phase significantly impacted the post-test results. While a concerted attempt was made to alter staff practices and guard against anticipated problems, changes did not occur quickly or in the absence of difficulties. Had the implementation period been at least equal to the 6-month pretest period, staff ratings and client file data might reveal an increase in measurement use, as specialists' familiarity with the measures, opportunities to use the measures, and chances to work through the problems discovered during this study increased. This proposed time frame is reasonable, since the evaluation patterns measured in the pretest phase had 2 years in which to evolve.

Two other problems identified in this study should be addressed before the upgrading of program evaluation practices continues. The first relates to the attitudes of program staff surrounding program evaluation in general and this pilot project in particular. It was noted earlier that many specialists did not take advantage of opportunities to use the new measures, and that their regular use was not enforced at the management level. Workers and supervisors do not appear to view evaluation as a priority undertaking, despite their enthusiasm and good intentions. This needs to change, or future improvements to program evaluation will not have the desired impact.

A second and related problem involves increasing staff workloads. During this study, the program budget was substantially reduced, administrative and support staff positions were eliminated, and specialist case loads and paper workloads increased. During the pretest phase, the majority of staff identified work demands as a primary obstacle to instrument use. It stands to reason that this problem also existed during the post-test interval. Therefore, there is a need to locate and devote more resources to evaluation duties.

Although the introduction of appropriate measures, in-service training, and the use of a comprehensive data package yielded positive ratings from staff group, the pervasive nature of the above problems calls for creative solutions that can shift the cost-benefit ratio of program evaluation in the desired direction. In Chapter 6, the implications of these results and the future of program evaluation is discussed.

CHAPTER 6
CONCLUSIONS

In this chapter, evaluation problems of relevance to family support programs are addressed, and the importance of evaluation in future is discussed.

During the course of this project, attempts were made to upgrade evaluation procedures in the short term program. Through careful research and planning, it was hoped that most of the barriers to outcome evaluation inherent in the field, family support programs, and the short term program would be alleviated. The modest project results described in Chapter 5 highlight both the promise and problems associated with program evaluation. It was learned that while staff familiarity with program measures, their satisfaction with the outcome data package, and the consistency of assessments within client cases modestly increased, the number of specialists using program measures and the overall consistency and frequency of client assessments remained unchanged, except for a small increase in the number of assessments performed at case closure. While staff identified competing work demands, limited opportunities for the clinical use of program instruments, and lack of support and monitoring at the supervisory level as the primary obstacles to instrument use, they acknowledged the importance of program evaluation and research and concurred that the new measures promoted competency and yielded valuable feedback.

The positive results would suggest that the selection of comprehensive and relevant measures and training in their use have diminished some of the problems attached to program evaluation.

However, the failure of this pilot to increase the frequency of instrument use among all specialists and across all stages of client intervention suggests that for specialists, the costs have outweighed the benefits of program evaluation.

Recommendations

In Chapter 5, the main obstacles to instrument use were identified as the restrictive timelines of the project, the failure of staff to treat program evaluation as a priority undertaking, and limited program and staff resources. It is hoped that the following recommendations will yield positive results in future for the short term program, as well as for family support programs faced with similar challenges.

First, it is likely that the results of this project were not captured in their entirety because new evaluation patterns had not yet been fully formed at the time of the post-test. Nevertheless, the project results accurately depict the primary obstacles to meeting project objectives, indicate some desired change in the general direction of positive practices, and shed some light on the relationship between study outcomes and a number of variables. Indeed, other programs would be wise to follow suit and assess the effectiveness of particular strategies early in the pilot phase, so they can make necessary changes before a decision regarding the effectiveness of new approaches is reached. Further, once evaluation patterns have had time to stabilize, a final assessment would provide a more accurate picture of project outcomes. For the short term program, this means that the information learned in this study should be used to further upgrade

program evaluation practices, and that another assessment should be performed once these strategies have had an opportunity to fully impact evaluation practices. By viewing this study period as a first step to improving program evaluation, objectives can continue to be met.

Second, staff identified their heavy case and paper workload as a primary obstacle to instrument use. Wasik, Bryant, and Lyons (1990) cite this as a common problem in the social services field, and warn that it frequently leads to worker "burnout". One main culprit, shrinking program budgets, can have a negative impact on staff resources, as well as on quality assurance and staff morale. For example, the Prenatal/Early Infancy Project employed home visiting nurses to provide health and other support services to disadvantaged pregnant mothers. When program funds were slashed and case workloads increased, the nurses reported that their "...work seemed less valued and [they] felt they couldn't give their clients the kind of support they required" (Schorr, 1989, p. 174). Dissatisfied, these nurses eventually left the program. In addition, it was no longer possible for the program to finance evaluation studies to determine the effectiveness of these step-down services.

To buffer against these negative effects, programs must find ways to reallocate existing resources, so that service quality remains high and evaluation practices can continue to be upgraded. Similarly, the short term program needs to examine ways in which its resources are currently being used. For example, specialists claim to spend a significant portion of their time documenting client interventions. Wasik, Bryant, and Lyons (1990) warn against too little or too

much documentation, and explain that the latter can result in poor quality records. Cole and Duva stress that documentation should be "...kept to a minimum...and not [be] too duplicative" (Cole & Duva, 1990, p. 52). Several programs have already attempted to solve the problem of limited resources. Some Calgary-based social workers audiotape their meetings and submit the narratives to clerical staff for typing, while the Infant Health and Development Program (Wasik, Bryant, and Lyons, 1990) uses standard check list summary forms so workers can briefly record pertinent information on their professional and client contacts. This information is then stored in a computer and used to track individual client progress and the effectiveness of various sites. For family specialists in the short term program and other programs, further examination and streamlining of documentation procedures would be helpful. Indeed, a program technology meeting has been scheduled to discuss ways in which staff can deal with the loss of personnel and cope effectively with their increasing job demands. This is an appropriate forum in which to discuss the need for evaluation resources.

In retrospect, the problem of increasing work demands was probably exacerbated by the sudden introduction of three new instruments to the program at the beginning of this study. The introduction of one measure at a time for program use may have yielded better results, as staff found ways to gradually incorporate these responsibilities into their work routine.

A third obstacle to evaluation follow-through is the way staff view program evaluation. While staff in the short term program recognize its value, they do not treat outcome evaluation as

a priority. This was evident at both the supervisory level and front-line level. As was mentioned earlier, budget cuts and increased workload demands can leave staff feeling devalued, disempowered, and unable to effectively perform their responsibilities. Because evaluation responsibilities were carried out in the past whenever resources became available, it is understandable that other work responsibilities would continue to take precedence over evaluation.

There are several ways to engage staff in the evaluation process. One is to increase the level of support and monitoring at the supervisory level. If coordinators expect staff to take evaluation seriously, they must use their leadership skills to encourage and motivate front-line staff. Everyone must feel that evaluation is a shared responsibility. A second suggestion is to allow staff the freedom to make more decisions involving evaluation. The majority of the post-test group used program measures only when they felt them to be of clinical significance. Those who did not may have felt that their choices were too limited. While all staff should use at least one standardized pre and post outcome measure (in this case, the Family Assessment Device), specialists should be allowed to choose from a battery of instruments, based on their clinical decisions, program guidelines, and the individualized needs of their clients. For example, the use of Hudson's Multi-Problem Screening Inventory (MPSI) Depression subscale with a depressed parent, or the assessment of an adolescent sexual perpetrator using the Wilson Sexual Fantasy Questionnaire would allow staff to address the specific problems encountered by family

members. Further, by selecting their own measures from an available pool which they help to form, specialists are more likely to feel empowered and invested in the evaluation process. Recall in Chapter 2 how one local professional remarked that involving practitioners in the creation of a program measure increased their investment level, despite the time-consuming nature of the instrument. The type of measures used and their popularity can also assist with the identification of the clinical populations most frequently served by the program.

A third way to engage staff is to increase their sense of ownership with regards to evaluation. By expanding the formal job description of specialists to include that of evaluator, they are more likely to feel this responsibility is a valued and recognized part of their work identity. This will likely prove most successful with new recruits, whose expectations of the work role have not yet been formed. Two new workers have already received pre-service training in the use of program outcome measures, which will further contribute to their investment in evaluation practices.

It is hoped that the above recommendations will yield positive results in the short term program, and contribute to the learning of other professionals. The documents and training package introduced during this project have been adopted for use by the program. Also, the research outcome data that is being collected quarterly for this fiscal year will be shared with professionals from other agencies during the Annual Meeting, and will be presented in an annual program report titled "Schedule A" to the Department of Social Services. I will continue to make improvements to program evaluation, and plan to conduct another assessment of the pilot

once staff have had an opportunity to use the measures and once the program has approved and accommodated the proposed changes.

Final Comments

The results of this project have highlighted the persistent challenges associated with program evaluation. Information on barriers such as economic hardship, staff resistance, and the magnitude of change required to bring evaluation practices to an acceptable level, serve to put the results of this study into perspective and balance the expectations of those attempting to improve staff practices. While effective evaluation procedures require considerable time and energy, programs should maintain a sense of urgency because history has taught us that time brings with it new changes.

One anticipated change is the era of managed care (Monack, 1995). Gaining popularity in the public and private arenas of America, its primary goal is to reduce the cost of services such as hospitalized or institutionalized care, and more adequately meet the needs of disadvantaged populations at the community level. For example, Medicaid-funded programs will allegedly spare federal money and reserve state funds for the continuing development of community services. New words such as consumer demand, multidimensional service delivery, and regulated services, replace familiar concepts such as fee-for-service care. Although Canada has not yet reached a verdict, the local deterioration of the Alberta Health Care system and the closure of three Calgary hospitals makes it likely these neighbors will follow suit.

The implication of managed care is that the "...demand for community-based services...with documented positive outcomes is increasing" (Monack, 1995). As states and provinces pay more attention to the services they are purchasing and less to credentialling and service availability, programs will need to demonstrate their effectiveness using sound evaluation practices. In so doing, they may be delegated as key players and decision makers.

In summary, even though the results of this study are disappointing, the persistent problems and small gains associated with upgraded evaluation practices in the short term program provide a basis on which to build future efforts. Aware of the challenges and armed with the means and motivation to overcome them, it is hoped that evaluation can eventually serve its intended purpose within all family support programs. Efforts to strengthen and substantiate quality assurance must continue and must include the creation of work settings that are conducive and receptive to evaluation development and practices.

References

Achenbach, T. M. (1985). Assessment and taxonomy of child and adolescent psychopathology. Newbury Park, CA: Sage Publications.

Besharov, D. J., & Baehler, K. (1992). Demonstration and evaluation strategies. Children and Youth Services Review, 14, 1-18.

Bond, J. T., & Halpern, R. (1988). The cross-project evaluation of the Child Survival/Fair Start initiative: A case study of action research. In H. B. Weiss & F. H.Jacobs (Eds.), Evaluating family programs (pp. 347-370). NY: Aldine de Gruyter.

Cleary, P. D. (1988). Social support: Conceptualization and measurement. In H. B. Weiss & F. H. Jacobs, Evaluating family programs (pp. 195-216). NY: Aldine de Gruyter.

Cole, E., & Duva, J. (1990). Family preservation: An orientation for administrators and practitioners. Washington, DC: Child Welfare League of America.

Corcoran, K., & Fischer, J. (1987). Measures for clinical practice: A source book. New York: The Free Press.

Dunst, C. J. (1991). Evaluating family resource programs. In Family Resource Coalition Report, 10 (1), (pp. 15-16).

Dunst, C., Trivette, C., & Deal, A. (1988). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline Books.

Ellwood, A. (1988). Prove to me that MELD makes a difference. In H. B. Weiss, & F. H. Jacobs (Eds.), Evaluating family programs (pp. 303-313). NY: Aldine de Gruyter.

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. Journal of Marital and Family Therapy, April, 9 (2), 171-180.

Fetterman, D. M. (1986). Beyond status quo in ethnographic educational evaluation. In D. M. Fetterman & M. A. Pitman (Eds.), Educational Evaluation: Ethnography in theory, practice, and politics (pp. 9-21). Beverly Hills, CA: Sage Publications.

Fleuridas, C., Rosenthal, D. M., Leigh, G. K., & Leigh, T. E. (1990). Family Goal Recording: An adaptation of Goal Attainment Scaling for enhancing family therapy and assessment. Journal of Marital and Family Therapy, October, 16, (4), 389-406.

Fristad, M. A. (1989). A comparison of the McMaster and Circumplex Family Assessment instruments. Journal of Marital and Family Therapy, 15 (3), 259-269.

Gabor, P., Thomlison, B., & Hudson, W. W. (1993, March-April). Planning treatment services for children: Development of the problem-oriented Family Assessment Screening Innentory. Paper presented at Finding Better Ways For High Risk Children, Youth, and Their Families, Cambridge, MA.

Green, R. G., Harris, R. N., Forte, J. A., & Robinson, M. (1991). Evaluating FACES III and the Circumplex Model: 2,440 families. Family Process, March, 30, 55-73.

Jacobs, F. H. (1988). The five-tiered approach to evaluation: Context and implementation. In H. B. Weiss & F. H. Jacobs (Eds.), Evaluating family programs (pp. 37-68). NY: Aldine de Gruyter.

Kinney, J., Haapala, D., & Booth, C. (1991). Keeping families together: The Homebuilders Model. NY: Aldine de Gruyter.

Lam, T. C. M. (1992). Review of practices and problems in the evaluation of bilingual education. Review of Educational Research, Summer, 62 (2), 181-203.

Littel, J. H. (1986). Building strong foundations: Evaluation strategies for family resource programs. Chicago, IL: Family Resource Coalition.

McCroskey, J., & Nelson, J. (1989). Practice-based research in a family support program: The Family Connection Project example. Child Welfare League of America, November-December, 68 (6), 573-587.

McFall, R. M. (1986). Theory and method in assessment: The vital link. Behavioral Assessment, 8 (3), 3-10.

McMahon, R. J. (1984). Behavioral checklists and rating scales. In T. H. Ollendick & M. Herson (Eds.), Child behavior assessment: Principles and procedures (pp. 80-105). NY: Permagon Press.

Miller, I. W., Bishop, D. S., Epstein, N. B., & Keitner, G. I. (1985). The McMaster Family Assessment Device: Reliability and validity. Journal of Marital and Family Therapy, 11 (4), 345-356.

Monack, D. R. (1995). Medicaid and managed care: Opportunities for innovative service delivery to vulnerable populations. Behavioral Healthcare Tomorrow, March/April.

Mooney, K. C. (1984). Child Behavior Checklist. In D. J. Keyser, & R. C. Sweetland (Eds.), Test Critiques (Vol. 1) (pp.168-184). Kansas City, MO: Test Corporation of America.

Olson, D. H., & Portner, J. (1983). Family Adaptability and Cohesion Evaluation Scales. In E. E. Filsinger (Ed.), Marriage and family assessment: A sourcebook for family therapy (pp. 299-315). Beverly Hills, CA: Sage Publications.

Perosa, L. M., & Perosa, S. L. (1990). The use of a bipolar item format for FACES II: A reconsideration. Journal of Marital and Family Therapy, April, 16 (2), 187-199.

Powell, D. R. (1987). Methodological and conceptual issues in research. In S. L. Kagan, D. R. Powell, B. Weissbourd, & E. F. Zigler (Eds.), America's family support programs: Perspectives and prospects (pp. 311-328). New Haven, CT: Yale University Press.

Procidano, M. E., & Heller, K. (1983). Measures of Perceived Social Support From Friends and From Family: Three validation studies. American Journal of Community Psychology, 11 (1), 1-24.

Rankin, H. (1990). Validity of self-reports in clinical settings. Behavioral Assessment, 12, 107-116.

Reichardt, C. S., & Rallis, S. F. (1994). Qualitative and quantitative inquiries are not incompatible: A call for a new partnership. New Directions for Program Evaluation, Spring, (61), 85- ?.

Rodriguez, G. G., & Cortez, C. P. (1988). The evaluation experience of the Avance Parent-Child Education Program. In H. B. Weiss, & F. H. Jacobs (Eds.), Evaluating family programs (pp. 287-313). New York: Aldine de Gruyter.

Rossi, P. H. (1992). Assessing family preservation programs. Children and Youth Services Review, 14, 77-97.

Royse, D. (1990). Research methods in social work. Chicago, IL: Nelson-Hall.

Sawyer, M. G., Sarris, A., Baghurst, P., Cross, D. G., & Kalucy, R. S. (1988). Family Assessment Device: Reports from mothers, fathers, and adolescents in community and clinic families. Journal of Marital and Family Therapy, July, 14 (3), 287-296.

Schorr, L. B. (1989). Within our reach: Breaking the cycle of disadvantage. NY: Anchor Books.

Scriven, M. (1993). The nature of evaluation. New Directions for Program Evaluation, Summer (58), 5-?.

Tardy, C. H. (1985). Social support measurement. American Journal of Community Psychology, 13 (2), 187-201.

Turner, R. J., & Avison, W. R. (1985). Assessing risk factors for problem parenting: The significance of social support. Journal of Marriage and the Family, November, 47 (4), 881-892.

Walker, D. K., & Crocker, R. W. (1988). Measuring family systems outcomes. In H. B. Weiss & F. H. Jacobs (Eds.), Evaluating family programs (pp. 153-176). NY: Aldine de Gruyter.

Wasik, B. H., Bryant, D. M., & Lyons, C. M. (1990). Home visiting: Procedures for helping families. Newbury Park, CA: Sage Publications.

Waxman, T. G., Rapagna, S., & Dumont, F. (1991). Scripted thinking and faulty problem representation: The effects of theoretical orientation, level of experience, and temporal order on causal judgement. Canadian Journal of Counselling, 25 (2), 146-169.

Weiss, R. L., & Frohman, P. E. (1985). Behavioral observation as outcome measures: Not through a glass darkly. Behavioral Assessment, 7, 309-315.

Yin, R. K. (1994). Evaluation: A singular craft. New Directions for Program Evaluation, Spring, (61), 71-85.?

Zigler, E. F., & Freedman, J. (1987). Head Start: A pioneer of family support. In S. Kagan, D. R. Powell, B. Weissbourd, & E. Zigler (Eds.), America's family support programs: Perspecitives and prospects (pp. 57-76).

APPENDIX A

Parent-Child Behavior Questionnaire (PCBQ) and Child Behavior Checklist (CBCL)

I.D. __ __ - __ __ - __ __ __

FAMILY:_____ DATE:_____

NAME OF PARENT FILLING OUT QUESTIONNAIRE:_____ ____ Pre ____ Post ____ 18 Week Follow-up

INTERACTION BEHAVIOUR QUESTIONNAIRE (PCBQ)

Below is a list of statements that may or may not be true about (name) _____. Consider the last four weeks only. For those statements that are mostly true, circle YES, for those that are mostly false, circle NO. Try not to leave any blanks.

True	False	1.	My child is easy to get along with.
True	False	2.	My child is well behaved in our discussions.
True	False	3.	My child is receptive to criticism.
True	False	4.	For the most part, my child likes to talk to me.
True	False	5.	We almost never seem to agree.
True	False	6.	My child usually listens to what I tell him/her.
True	False	7.	At least three times a week, we get angry at each other.
True	False	8.	My child says that I have no consideration of his/her feelings.
True	False	9.	My child and I compromise during arguments.
True	False	10.	My child often doesn't do what I ask.
True	False	11.	The talks we have are frustrating.
True	False	12.	My child often seems angry at me.
True	False	13.	My child acts impatient when I talk.
True	False	14.	In general, I don't think we get along very well.
True	False	15.	My child almost never understands my side of an argument.
True	False	16.	My child and I have big arguments about little things.
True	False	17.	My child is defensive when I talk to him.
True	False	18.	My child thinks my opinions don't count.
True	False	19.	We argue a lot about rules.
True	False	20.	My child tells me he/she thinks I am unfair.

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

For office use o
ID #

CHILD'S NAME

SEX ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo _____ Date _____ Yr _____

CHILD'S BIRTHDATE Mo _____ Date _____ Yr _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. (Pl
Be specific – for example, auto mechanic, high school teacher, homem
laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY:

☐ Mother (name) _____

☐ Father (name) _____

☐ Other – name & relationship to child: _____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do ea one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Averag
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do eac one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

BEST COPY AVAILABLE

V. 1. About how many close friends does your child have? (Do not include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do not include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work by himself/herself?	☐	☐	☐	

VII. 1. For ages 6 and older – performance in academic subjects. If child is not being taught, please give reason _____

	Failing	Below average	Average	Above average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects – for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Is your child in a special class or special school? ☐ No ☐ Yes – what kind of class or school?

3. Has your child repeated a grade? ☐ No ☐ Yes – grade and reason

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes – please describe

When did these problems start?

Have these problems ended? ☐ No ☐ Yes – when?

Does your child have any illness, physical disability, or mental handicap? ☐ No ☐ Yes – please describe

What concerns you most about your child?

Please describe the best things about your child:

BEST COPY AVAILABLE

Below is a list of items that describe children. For each item that describes your child now or within the past 6 months circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do nc to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Ofte

0 1 2 [a]1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____

0 1 2 [a]3. Argues a lot
0 1 2 4. Asthma

0 1 2 [a]5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet

0 1 2 [a]7. Bragging, boasting
0 1 2 [a]8. Can't concentrate, can't pay attention for long

0 1 2 [a]9. Can't get his/her mind off certain thoughts; obsessions (describe): _____

0 1 2 [a]10. Can't sit still, restless, or hyperactive

0 1 2 [a]11. Clings to adults or too dependent
0 1 2 [a]12. Complains of loneliness

0 1 2 [a]13. Confused or seems to be in a fog
0 1 2 [a]14. Cries a lot

0 1 2 15. Cruel to animals
0 1 2 [a]16. Cruelty, bullying, or meanness to others

0 1 2 [a]17. Day-dreams or gets lost in his/her thoughts
0 1 2 [a]18. Deliberately harms self or attempts suicide

0 1 2 [a]19. Demands a lot of attention
0 1 2 [a]20. Destroys his/her own things

0 1 2 [a]21. Destroys things belonging to his/her family or other children
0 1 2 22. Disobedient at home

0 1 2 [a]23. Disobedient at school
0 1 2 24. Doesn't eat well

0 1 2 [a]25. Doesn't get along with other children
0 1 2 [a]26. Doesn't seem to feel guilty after misbehaving

0 1 2 [a]27. Easily jealous
0 1 2 28. Eats or drinks things that are not food – don't include sweets (describe): _____

0 1 2 [a]29. Fears certain animals, situations, or places, other than school (describe): _____

0 1 2 [a]30. Fears going to school

0 1 2 [a]31. Fears he/she might think or do some bad

0 1 2 [a]32. Feels he/she has to be perfect
0 1 2 [a]33. Feels or complains that no one loves

0 1 2 [a]34. Feels others are out to get him/her
0 1 2 [a]35. Feels worthless or inferior

0 1 2 [a]36. Gets hurt a lot, accident-prone
0 1 2 [a]37. Gets in many fights

0 1 2 [a]38. Gets teased a lot
0 1 2 [a]39. Hangs around with children who get trouble

0 1 2 [a]40. Hears sounds or voices that aren't (describe): _____

0 1 2 [a]41. Impulsive or acts without thinking

0 1 2 [a]42. Likes to be alone
0 1 2 [a]43. Lying or cheating

0 1 2 [a]44. Bites fingernails
0 1 2 [a]45. Nervous, highstrung, or tense

0 1 2 [a]46. Nervous movements or twitching (de: _____

0 1 2 47. Nightmares

0 1 2 [a]48. Not liked by other children
0 1 2 49. Constipated, doesn't move bowels

0 1 2 [a]50. Too fearful or anxious
0 1 2 [a]51. Feels dizzy

0 1 2 [a]52. Feels too guilty
0 1 2 53. Overeating

0 1 2 [a]54. Overtired
0 1 2 [a]55. Overweight

56. Physical problems without known m cause:
0 1 2 [a]a. Aches or pains
0 1 2 [a]b. Headaches
0 1 2 [a]c. Nausea, feels sick
0 1 2 [a]d. Problems with eyes (describe): _____
0 1 2 [a]e. Rashes or other skin problems
0 1 2 [a]f. Stomachaches or cramps
0 1 2 [a]g. Vomiting, throwing up
0 1 2 h. Other (describe): _____

BEST COPY AVAILABLE

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	a	57.	Physically attacks people
0	1	2	a	58.	Picks nose, skin, or other parts of body (describe): _____
0	1	2		59.	Plays with own sex parts in public
0	1	2		60.	Plays with own sex parts too much
0	1	2	a	61.	Poor school work
0	1	2	a	62.	Poorly coordinated or clumsy
0	1	2	a	63.	Prefers being with older kids
0	1	2	a	64.	Prefers being with younger kids
0	1	2	a	65.	Refuses to talk
0	1	2	a	66.	Repeats certain acts over and over; compulsions (describe): _____
0	1	2		67.	Runs away from home
0	1	2	a	68.	Screams a lot
0	1	2	a	69.	Secretive, keeps things to self
0	1	2	a	70.	Sees things that aren't there (describe):
0	1	2	a	71.	Self-conscious or easily embarrassed
0	1	2		72.	Sets fires
0	1	2		73.	Sexual problems (describe): _____
0	1	2	a	74.	Showing off or clowning
0	1	2	a	75.	Shy or timid
0	1	2		76.	Sleeps less than most kids
0	1	2		77.	Sleeps more than most kids during day and/or night (describe): _____
0	1	2		78.	Smears or plays with bowel movements
0	1	2	a	79.	Speech problem (describe): _____
0	1	2		80.	Stares blankly
0	1	2		81.	Steals at home
0	1	2	a	82.	Steals outside the home
0	1	2	a	83.	Stores up things he/she doesn't need (describe): _____
0	1	2	a	84.	Strange behavior (describe): _____
0	1	2	a	85.	Strange ideas (describe): _____
0	1	2	a	86.	Stubborn, sullen, or irritable
0	1	2	a	87.	Sudden changes in mood or feelings
0	1	2		88.	Sulks a lot
0	1	2	a	89.	Suspicious
0	1	2	a	90.	Swearing or obscene language
0	1	2	a	91.	Talks about killing self
0	1	2		92.	Talks or walks in sleep (describe): _____
0	1	2	a	93.	Talks too much
0	1	2	a	94.	Teases a lot
0	1	2	a	95.	Temper tantrums or hot temper
0	1	2	a	96.	Thinks about sex too much
0	1	2	a	97.	Threatens people
0	1	2		98.	Thumb-sucking
0	1	2	a	99.	Too concerned with neatness or cleanliness
0	1	2		100.	Trouble sleeping (describe): _____
0	1	2	a	101.	Truancy, skips school
0	1	2	a	102.	Underactive, slow moving, or lacks energy
0	1	2	a	103.	Unhappy, sad, or depressed
0	1	2	a	104.	Unusually loud
0	1	2	a	105.	Uses alcohol or drugs for nonmedical purposes (describe): _____
0	1	2		106.	Vandalism
0	1	2		107.	Wets self during the day
0	1	2		108.	Wets the bed
0	1	2		109.	Whining
0	1	2		110.	Wishes to be of opposite sex
0	1	2	a	111.	Withdrawn, doesn't get involved with others
0	1	2	a	112.	Worries
				113.	Please write in any problems your child ha that were not listed above:
0	1	2			_____
0	1	2			_____
0	1	2			_____

MAKE SURE YOU HAVE ANSWERED ALL ITEMS

UNDERLINE ANY YOU ARE CONCERNED ABOUT

BEST COPY AVAILABLE

APPENDIX B

Specialist Questionnaire

PROGRAM OUTCOME MEASURES

Instructions

As part of a Master's level practicum project, you have been asked to provide information that will be used to develop and upgrade outcome evaluation practices in the short term program Please read each each section carefully, answer the corresponding questions by circling the appropriate response, and comment briefly in the spaces provided. Individual responses will remain confidential. Thank you for your cooperation

PROGRAM OUTCOME MEASURES

The Achenbach's Child Behavior Checklist (CBCL) and page 1 of the Parent Child Behavior Checklist (PCBQ) are designed to provide program staff with feedback on the treatment of troubled youth, that furthers the development of program research. At intake, specialists ask their clients to provide written consent to participate in program research. If consent is obtained, one or both parents complete these questionnaires within 2 weeks of opening, at case closure, and at 4 months following case closure.

Part A

(1) How useful are the 2 existing instruments in measuring changes that take place *within* program families?

Extremely Useful **Useful** **Not Useful** **Not At All Useful**

Comments_____

(2) How consistent is the questionnaire data with your own observations regarding family situations and progress toward goals?

Highly Consistent **Consistent** **Inconsistent** **Highly Inconsistent**

Comments_____

(3) From what percentage of your case families do you request consent to implement these measures?

_____%

Comments_____

(4) How often do you issue these measures within 2 weeks of case opening with consenting families?

Always **Frequently** **Seldom** **Never**

Comments_____

(5) How often do you issue these measures at case closure with consenting families?

Always **Frequently** **Seldom** **Never**

Comments_____

(6) How often do you issue these measures at 4-month follow up with consenting families?

Always **Frequently** **Seldom** **Never**

Comments_____

(6) How often do you issue these measures at 4-month follow up with consenting families?

Always **Frequently** **Seldom** **Never**

Comments_____

(7) How often do you use the questionnaire results to plan further clinical decisions?

Always **Frequently** **Seldom** **Never**

Comments_____

(8) How often do you share the questionnaire results with other professionals (such as during case conferences, and in termination reports)?

Always **Frequently** **Seldom** **Never**

Comments_____

(9) What percentage of your clients who are asked agree to participate in program *research*?

_____%

Comments_____

(10) How would you rate your own skills in statistically computing the questionnaire data?

Highly Skilled **Skilled** **Unskilled** **Highly Unskilled**

Comments_____

(11) How would you rate your ability to clinically interpret the questionnaires?

Highly Capable **Capable** **Incapable** **Extremely Incapable**

Comments_____

(12) How would you rate the adequacy of pre-service and in-service training in preparing you for the administration of the questionnaires and the interpretation of questionnaire data?

Extremely Adequate **Adequate** **Inadequate** **Extremely Inadequate**

Comments_____

(13) How would you rate the questionnaires on their benefit to the program?

Extremely Beneficial **Beneficial** **Not beneficial** **Not At All Beneficial**

Comments_____

(14) How difficult is it for you to find time to complete the questionnaires given your work demands?

Extremely Difficult **Difficult** **Easy** **Extremely Easy**

Comments_____

(15) In your opinion, to what degree are the benefits of *research* worthy of your time and energy?

Highly Worthy **Worthy** **Unworthy** **Highly Unworthy**

Comments_____

(16) When families decline participation in *research*, rate the importance of reasons.

(a) They do not understand what their commitment will involve.

Extremely Important **Important** **Unimportant** **Extremely Unimportant**

Comments_____

(b) They feel it offers no immediate benefits to their family.

Extremely Important **Important** **Unimportant** **Extremely Unimportant**

Comments_____

(c) They are not satisfied with the ethical and confidentiality assurances program staff have made.

Extremely Important **Important** **Unimportant** **Extremely Unimportant**

Comments_____

(17) What percentage of the time do you find it difficult to contact families at 4-month follow-up periods to issue the questionnaires?

_____%

Comments_____

Child placement is considered a primary outcome variable that provides program staff, professionals, and contract managers with feedback on program effectiveness. At case closure and thereafter over a 1-year period families are contacted quarterly by available staff and are asked to describe child placement during each month of the reporting period.

Part B

(18) How often do you collect child placement data during 1-year follow-up intervals?

Always **Frequently** **Seldom** **Never**

Comments_____

(19) How consistent is the collection of child placement data du ng quarterly follow-up periods?

Extremely Consistent **Consistent** **Inconsistent** **Extremely Inconsistent**

Comments_____

(20) How often do you receive feedback on child placement data gathered by program staff?

Always **Frequently** **Seldom** **Never**

Comments_____

(21) How appropriate is the current outcome data package in providing sufficient family information to target groups (such as program staff and contract managers)?

Extremely Appropriate **Appropriate** **Inappropriate** **Extremely Inappropriate**

Comments_____

(22) How appropriate is the existing child placement data as a single indicator of case outcome?

Extremely Appropriate **Appropriate** **Inappropriate** **Extremely Inappropriate**

Comments_____

(23) How pressured do you feel to ensure in-home placement?

Extremely Pressured **Pressured** **Not Pressured** **Not At All Pressured**

Comments_____

In the following section please comment in more detail, or add any information not covered previously in the body of the questionnaire.

Part C

(1) Comments related to the outcome measures used by the program:

2) Comments related to the consistent application of the outcome measures:

(3) Comments related to the adequate use of data provided by the outcome measures:

NOVA UNIVERSITY
ABRAHAM S. FISCHLER CENTER FOR THE
ADVANCEMENT OF EDUCATION
3301 College Avenue
Fort Lauderdale, Florida 33314

VERIFICATION OF PRACTICUM PROJECT STATEMENT

STATEMENT II - To be attached to the Practicum Report.

I verify that the below named student did conduct the practicum project described in the submitted Practicum Report and I attest to the fact that this practicum project was carried out by the student in a responsible, professional and competent manner.

Practicum Title THE DEVELOPMENT OF OUTCOME MEASURES FOR A FAMILY PRESERVATION AND REUNIFICATION PROGRAM

Student's Name GAIL COATES **Cohort** 8F

Verifier's Name KAREN BLASE (PhD)

Verifier's Position FORMER AGENCY MANAGING DIRECTOR

Verifier's Relationship to Student FORMER EMPLOYER

Name of Verifier's Work Setting FYI CONSULTING, LTD.

Address 4 LAKE ROSEN PLACE SE

CALGARY (City) AB (State) T3M 2 (Zip)

Telephone Number (403) 271-0969 (business)

Verifier's Signature Karen C. Blase

Date Dec 5, 1995

BEST COPY AVAILABLE

APPENDIX C

Family Assessment Device (FAD)

Enclosed please find the FAD packet that you ordered. You have permission to duplicate the copyrighted Family Assessment Device, the manual scoring sheet and instructions, and the Family Information Form. We may contact you in the future to receive your feedback on the instrument.

Thank you for your interest and good luck in your future project.

Sincerely,

Ivan W. Miller, Ph.D.
Director
Brown University Family
Research Program
Butler Hospital
345 Blackstone Blvd.
Providence, R. I. 02906

IWM/
Enclosure

BEST COPY AVAILABLE

Version 3

Nathan B. Epstein, M.D.
Lawrence M. Baldwin, Ph.D.
Duane S. Bishop, M.D.

The Brown University/Butler Hospital Family Research Program
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island 02906

Date of Administration: _____

Family Role: _____

Identification Number or Family Name: _____

Copyrighted 2/23/82

FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

ID _____ _____ _____

1. Planning family activities is difficult because we misunderstand each other.

   _____ SA _____ A _____ D _____ SD _____

2. We resolve most everyday problems around the house.

   _____ SA _____ A _____ D _____ SD _____

3. When someone is upset the others know why.

   _____ SA _____ A _____ D _____ SD _____

4. When you ask someone to do something, you have to check that they did it.

   _____ SA _____ A _____ D _____ SD _____

5. If someone is in trouble, the others become too involved.

   _____ SA _____ A _____ D _____ SD _____

6. In times of crisis we can turn to each other for support.

   _____ SA _____ A _____ D _____ SD _____

7. We don't know what to do when an emergency comes up.

   _____ SA _____ A _____ D _____ SD _____

8. We sometimes run out of things that we need.

   _____ SA _____ A _____ D _____ SD _____

9. We are reluctant to show our affection for each other.

   _____ SA _____ A _____ D _____ SD _____

10. We make sure members meet their family responsibilities.

    _____ SA _____ A _____ D _____ SD _____

11. We cannot talk to each other about the sadness we feel.

    _____ SA _____ A _____ D _____ SD _____

12. We usually act on our decisions regarding problems.

    _____ SA _____ A _____ D _____ SD _____

FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

ID ____ ____ ____

13. You only get the interest of others when something is important to them.

____ SA ____ A ____ D ____ SD ____

14. You can't tell how a person is feeling from what they are saying.

____ SA ____ A ____ D ____ SD ____

15. Family tasks don't get spread around enough.

____ SA ____ A ____ D ____ SD ____

16. Individuals are accepted for what they are.

____ SA ____ A ____ D ____ SD ____

17. You can easily get away with breaking the rules.

____ SA ____ A ____ D ____ SD ____

18. People come right out and say things instead of hinting at them.

____ SA ____ A ____ D ____ SD ____

19. Some of us just don't respond emotionally.

____ SA ____ A ____ D ____ SD ____

20. We know what to do in an emergency.

____ SA ____ A ____ D ____ SD ____

21. We avoid discussing our fears and concerns.

____ SA ____ A ____ D ____ SD ____

22. It is difficult to talk to each other about tender feelings.

____ SA ____ A ____ D ____ SD ____

23. We have trouble meeting our bills.

____ SA ____ A ____ D ____ SD ____

24. After our family tries to solve a problem, we usually discuss whether it worked or not.

____ SA ____ A ____ D ____ SD ____

25. We are too self-centered.

____ SA ____ A ____ D ____ SD ____

26. We can express feelings to each other.

____ SA ____ A ____ D ____ SD ____

27. We have no clear expectations about toilet habits.

____ SA ____ A ____ D ____ SD ____

28. We do not show our love for each other.

____ SA ____ A ____ D ____ SD ____

29. We talk to people directly rather than through go-betweens.

____ SA ____ A ____ D ____ SD ____

30. Each of us has particular duties and responsibilities.

____ SA ____ A ____ D ____ SD ____

31. There are lots of bad feelings in the family.

____ SA ____ A ____ D ____ SD ____

32. We have rules about hitting people.

____ SA ____ A ____ D ____ SD ____

33. We get involved with each other only when something interests us.

____ SA ____ A ____ D ____ SD ____

34. There's little time to explore personal interests.

____ SA ____ A ____ D ____ SD ____

35. We often don't say what we mean.

____ SA ____ A ____ D ____ SD ____

36. We feel accepted for what we are.

____ SA ____ A ____ D ____ SD ____

FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

ID _____ _____ _____

37. We show interest in each other when we can get something out of it personally.

_____ SA _____ A _____ D _____ SD _____

38. We resolve most emotional upsets that come up.

_____ SA _____ A _____ D _____ SD _____

39. Tenderness takes second place to other things in our family.

_____ SA _____ A _____ D _____ SD _____

40. We discuss who is to do household jobs.

_____ SA _____ A _____ D _____ SD _____

41. Making decisions is a problem for our family.

_____ SA _____ A _____ D _____ SD _____

42. Our family shows interest in each other only when they can get something out of it.

_____ SA _____ A _____ D _____ SD _____

43. We are frank with each other.

_____ SA _____ A _____ D _____ SD _____

44. We don't hold to any rules or standards.

_____ SA _____ A _____ D _____ SD _____

45. If people are asked to do something, they need reminding.

_____ SA _____ A _____ D _____ SD _____

46. We are able to make decisions about how to solve problems.

_____ SA _____ A _____ D _____ SD _____

47. If the rules are broken, we don't know what to expect.

_____ SA _____ A _____ D _____ SD _____

48. Anything goes in our family.

_____ SA _____ A _____ D _____ SD _____

FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

49. We express tenderness.

_____ SA _____ A _____ D _____ SD _____

50. We confront problems involving feelings.

_____ SA _____ A _____ D _____ SD _____

51. We don't get along well together.

_____ SA _____ A _____ D _____ SD _____

52. We don't talk to each other when we are angry.

_____ SA _____ A _____ D _____ SD _____

53. We are generally dissatisfied with the family duties assigned to us.

_____ SA _____ A _____ D _____ SD _____

54. Even though we mean well, we intrude too much into each others lives.

_____ SA _____ A _____ D _____ SD _____

55. There are rules about dangerous situations.

_____ SA _____ A _____ D _____ SD _____

56. We confide in each other.

_____ SA _____ A _____ D _____ SD _____

57. We cry openly.

_____ SA _____ A _____ D _____ SD _____

58. We don't have reasonable transport.

_____ SA _____ A _____ D _____ SD _____

59. When we don't like what someone has done, we tell them.

_____ SA _____ A _____ D _____ SD _____

60. We try to think of different ways to solve problems.

_____ SA _____ A _____ D _____ SD _____

APPENDIX D

Personal Network Matrix (PNM)

Personal Network Matrix
(Version 2)

Carol M. Trivette & Carl J. Dunst

Name _____ Date _____

This questionnaire asks about people and groups that may provide you help and assistance. The scale is divided into three parts. Please read the instructions that go with each part before completing each section of the questionnaire.

Listed below are different individuals and groups that people often have contact with face to face, in a group, or by telephone. Please indicate for each source listed how often you have been in contact with each person or group during the *past month*. Please indicate any person or group with whom you have had contact not included on our list.

How frequently have you had contact with each of the following during the *past month*:	Not at All	Once or Twice	At Least 10 Times	At least 20 Times	Almost Every-Day
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members	1	2	3	4	5
11. Minister, Priest, or Rabbi	1	2	3	4	5
12. Co-workers	1	2	3	4	5
13. Baby Sitter	1	2	3	4	5
14. Day Care or School	1	2	3	4	5
15. Private Therapist for Child	1	2	3	4	5
16. Child/Family Doctors	1	2	3	4	5
17. Early Childhood Intervention Program	1	2	3	4	5
18. Hospital/Special Clinics	1	2	3	4	5
19. Health Department	1	2	3	4	5
20. Social Service Department	1	2	3	4	5
21. Other Agencies	1	2	3	4	5
22. _____	1	2	3	4	5
23. _____	1	2	3	4	5

BEST COPY AVAILABLE

INSTRUCTIONS

This part of the scale asks you to do two things: (A) Begin by listing up to 10 needs or activities that are *intact* with on a regular basis or who you might go to for help with any of the projects you have listed. concern to you. We call these things projects because they require our time and energy. Projects include Please indicate who would provide you help with each different project by checking the appropriate box things like finding a job, paying the bills, finishing school, playing with our children, going on vacation, responding to the person's name. teaching our child how to eat, and so on. (B) Write the first name and last initial of all the people you hav

(A) PROJECTS / (B) WHO DO YOU HAVE CONTACT WITH? →				(C) WHO COULD YOU ASK FOR HELP WITH EACH OF THE PROJECTS?							

100

Whenever a person needs help or assistance, he or she generally can depend upon certain persons or groups more than others. List below are different individuals, groups, and agencies that you might ask for help or assistance. For each source listed, please indica to what extent you could depend upon each person or group if you needed any type of help.

To what extend can you depend on any of the following for help or assistance when you need it:	Not at All	Some-times	Occasionally	Most of the Time	All of the Time
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members	1	2	3	4	5
11. Minister, Priest, or Rabbi	1	2	3	4	5
12. Co-workers	1	2	3	4	5
13. Baby Sitter	1	2	3	4	5
14. Day Care or School	1	2	3	4	5
15. Private Therapist for Child	1	2	3	4	5
16. Child/Family Doctors	1	2	3	4	5
17. Early Childhood Intervention Program	1	2	3	4	5
18. Hospital/Special Clinics	1	2	3	4	5
19. Health Department	1	2	3	4	5
20. Social Service Department	1	2	3	4	5
21. Other Agencies	1	2	3	4	5
22. _____	1	2	3	4	5
23. _____	1	2	3	4	5

Source: C.J. Dunst, C.M. Trivette, and A.G. Deal (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books. May be reproduced.

BEST COPY AVAILABLE

APPENDIX E

Family Goal Recording (FGR), Reproduced

FAMILY GOAL RECORDING (FGR): _____ _____ SUBSYSTEN GOAL AREAS

Weight of Subsystem (WS) ____%	Outcome Status	Level	GOAL A Weight (%)	GOAL B Weight (%)	GOAL C Weight (%)	GOAL D Weight (%)
	Optimal	1.0				
		.75				
		.50				
		.25				
	Present Base Rate	0.00				
		- 0.25				
		- 0.50				
		- 0.75				
	Deterioration	- 1.0				

I	Formula (subsystem goal area)	(A)Level: ____ XWeight: ____	(B)Level: ____ XWeight: ____	(C)Level: ____ XWeight: ____	(D)Level: ____ XWeight: ____
	Assessment(1):	-Score A: ____	-Score B: ____	-Score C: ____	-Score C: ____
	Assessment(2):	(A)L x W-____	(B)L x W-____	(C)L x W-____	(D)L x W-____
	Assessment(3):	(A)L x W-____	(B)L x W-____	(C)L x W-____	(D)L x W-____
	Assessment(4):	(A)L x W-____	(B)L x W-____	(C)L x W-____	(D)L x W-____

BEST COPY AVAILABLE

FGR SCORE TRACKING SHEET

Test Intervals	Formula	Subsystem	Scores	
Assessment # ____ Week # ____	II To calculate %age of goal attainment for each subsystem, add subsystem goal areas: (A) ___ + (B) ___ + (C) ___ + (D) = E	For Child Parent Family	(E) .____ = (E) .____ = (E) .____ =	* ____ % * ____ % * ____ %
	III To calculate %age of overall goal attainment, multiply each subsystem score by each subsystem weight: (E) ___ x WS ___ = (F) and add:	Child Parent Family	.____ .____ .____	
		%age of overall change	(F) .____ =	* ____ %
Assessment # ____ Week # ____	(A)___+ (B)___+ (C)___+ (D)___ (A)___+ (B)___+ (C)___+ (D)___ (A)___+ (B)___+ (C)___+ (D)___	For Child Parent Family	(E) .____ = (E) .____ = (E) .____ =	* ____ % * ____ % * ____ %
	(E) ___ x WS ___ (E) ___ x WS ___ (E) ___ x WS ___	Child Parent Family	.____ .____ .____	
		%age of overall change	(F) .____ =	* ____ %
Assessment # ____ Week # ____	(A)___+ (B)___+ (C)___+ (D)___ (A)___+ (B)___+ (C)___+ (D)___ (A)___+ (B)___+ (C)___+ (D)___	For Child Parent Family	(E) .____ = (E) .____ = (E) .____ =	* ____ % * ____ % * ____ %
	(E) ___ x WS ___ (E) ___ x WS ___ (E) ___ x WS ___	Child Parent Family	.____ .____ .____	
		%age of overall change	(F) .____ =	* ____ %
Assessment # ____ Week # ____	(A)___+ (B)___+ (C)___+ (D)___ (A)___+ (B)___+ (C)___+ (D)___ (A)___+ (B)___+ (C)___+ (D)___	For Child Parent Family	(E) .____ = (E) .____ = (E) .____ =	* ____ % * ____ % * ____ %
	(E) ___ x WS ___ (E) ___ x WS ___ (E) ___ x WS ___	Child Parent Family	.____ .____ .____	
		%age of overall change	(F) .____ =	* ____ %

104

BEST COPY AVAILABLE

APPENDIX F

Post-Test Revisions to Specialist Questionnaire

PROGRAM OUTCOME MEASURES

The Family Assessment Device (FAD), Personal Network Matrix (PNM), and Family Goal Recording (FGR) outcome measures are designed to provide program staff, clients, and target groups with consistent, relevant feedback that can assist with the assessment and treatment of children and families and determine client progress toward goals. At intake, clients must provide written consent to participate in counselling. Their commitment includes the completion of these evaluation instruments within 2 weeks of case opening and at case closure, and the completion of the FAD and PNM scales at 3 months following closure. Clients may also consent to the use of this data in program research.

Part A

(1) How useful are the 3 existing instruments in measuring changes that take place *within* program families?

Extremely Useful **Useful** **Not Useful** **Not At All Useful**

Comments_____

(2) How consistent is the questionnaire data with your own observations regarding family situations and progress toward goals?

Highly Consistent **Consistent** **Inconsistent** **Highly Inconsistent**

Comments_____

(3) From what percentage of your case families do you request consent to implement these measures?

_____%

Comments_____

(4) How often do you issue these measures within 2 weeks of case opening with consenting families?

Always **Frequently** **Seldom** **Never**

Comments_____

(5) How often do you issue these measures at case closure with consenting families?

Always **Frequently** **Seldom** **Never**

Comments_____

APPENDIX G

Consent to Participate in Counselling Form, Revised

WILLIAM ROPER HULL CHILD AND FAMILY SERVICES

FAMILY INITIATIVES

2266, Woodpark Avenue, S.W. *Calgary, Alberta, T2W 2Z8*

CLIENT AUTHORIZATION FOR COUNSELLING

The parent or legal guardian must sign this authorization for counselling form.

1. *Your signature authorizes your minor child(ren) to participate in the Family Initiatives Program.*
2. *Your signature also authorizes the Family Initiatives' staff to work with other household members during the period of Family Initiatives' counselling and follow-up.*
3. *Your signature further authorizes Family Initiatives' staff to obtain relevant family information using questionnaires, interviews, and other documents, to assist you and them in meeting intervention goals.*

Name(s) of children:
(Please print) _____

_____

_____

Parent/Legal Guardian:
(Please print) _____

_____

_____

EMERGENCY CONTACT (optional)

If Family Initiatives is unable to contact you in the event of an emergency, who may we contact?

NAME:_____ **PHONE:**_____
(Please print)

I have read and understand the above.

SIGNATURE OF PARENT/LEGAL GUARDIAN:_____

WITNESS:_____ **DATE:**_____

Calgary, Alberta, (403) 251-5770

pd\afss\clientau.frm

BEST COPY AVAILABLE

APPENDIX H

Termination Format Letter, Revised Page

The progress towards these goals was as follows:

1.

2.

3.

Points to consider when writing about goals:

- **Describe implementation of treatment**
- **Chart progress, change, strengths**
- **Realistically review ongoing problem areas**
- **Use specific language describing behavioral change, impact on family dynamics, counselling outcomes, etc.**
- **Link positive outcomes to intervention plan**
- **Include relevant statistical or clinical data to support your findings**

BEST COPY AVAILABLE

APPENDIX I

Client Discharge Form, Revised Page

Discharge Placement

Code	Service Description	Check One
1	Home of Parents	
2	Relatives/Friends	
3	Adoption	
4	Home with Counselling	
5	In-Home Support	
6	Foster Care	
7	Spec. Foster Care	
8	Receiving Home	
9	Group Home	
10	Residential - Open	
11	Residential - Closed	
12	Remand in Custody	
13	Supported Independent Living	
14	Living Independently	
15	Hospital (Physical)	
16	Hospital (Psych)	
17	Institutional	
18	Runaway/AWOL	
19	Other Parent	
20	Emergency Shelter	
21	Cedarbrae Teaching Home	
22	Interdependent Living Services	
23	Family Initiatives	
24	Radisson Receiving Home	
25	First Choice Assessment	
26	First Choice Parenting	
99	Unknown	

Discharge Planning

Discharged According to Plan: _____ Yes _____ No If No: Projected Long Range Goal: ____ Permanently In Care ____ Eventual return to Family, Relatives, Friends (Reunification)
How successful do you predict this child will be in the future? 1. Very successful, 2. Successful, 3 Neither Successful nor Unsuccessful, 4 Unsuccessful, 5 Very Unsuccessful, 9. Unknown.
How favourable are the conditions under which the youth is leaving the program? 1.Very Favorable, 2.Favorable, 3.Neither Favorable nor Unfavorable, 4.Unfavorable, 5.Very Unfavorable, 9. Unknown.
Comments Regarding Discharge Planning:

BEST COPY AVAILABLE

APPENDIX J

Outcome Evaluation Forms: Child Placement and Family Functioning

FAMILY INITIATIVES

OUTCOME EVALUATION DATA - CHILD PLACEMENT

A. Reporting Period:

	Month of Follow-Up											
	1	2	3	4	5	6	7	8	9	10	11	12
Child Sample Size												
(n)												
Child Placement												
* Least Restrictive Environment (%)												
*Restrictive Environment (%) *Permanent *Temporary												

B. Reporting Period:

	Month of Follow-Up											
	1	2	3	4	5	6	7	8	9	10	11	12
Child Sample Size												
(n)												
Child Placement												
* Least Restrictive Environment (%)												
*Restrictive Environment (%) *Permanent *Temporary												

* Least restrictive placement = family, relatives, friends
* Restrictive placement = province-funded in care
* Long-range plan (projected): permanently in care/temporarily in care (goal - reunification)

FAMILY INITIATIVES

OUTCOME EVALUATION DATA - FAMILY FUNCTIONING

Reporting Period:

* FAMILY FUNCTIONING (FAD)			
DIMENSIONS (7)	OPENING (n=)	CLOSING (n =)	FOLLOW-UP (n=)
Problem Solving			
Communication			
Roles			
Affective Responsiveness			
Affective Involvement			
Behavior Control			
General Functioning			

Reporting Period:

* FAMILY FUNCTIONING (FAD)		
OPENING (n=)	CLOSING (n=)	FOLLOW-UP (n=)

* Family Assessment Device (FAD)
Healthy 1----/----4 Unhealthy
2 cutoff